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A PRELIMINARY NOTE ON THE TREATMENT OF PERFORATED DUODENAL ULCER.

By Alan Newton, M.S. (Melb.),
Surgeon to Out-Patients, Melbourne Hospital,
and

W. W. S. Johnston, M.B., B.S. (Melb.),
Captain, A.A.M.C.; late Resident Surgeon, Melbourne Hospital.

Introduction.

The treatment of perforated duodenal ulcer is exclusively surgical, and it is now generally realized that it is egregious ignorance to delay the operation longer than is absolutely needful.

Should the patient be far from skilled surgical aid at the time of perforation, it is better that the operation should be performed under disadvantageous conditions than that precious time should be wasted in transport. Some remarks by Sir Astley Cooper¹ upon strangulated hernia apply equally well to perforated duodenal ulcer:—

"Now let me allude to the case of a late illustrious nobleman—I am almost afraid to mention names—who died of this disease; he was in the country, and, during his stay there had strangulated hernia; he was attended by a person of strong mind, and who had studied his profession with industry; he offered to perform the operation, but it was delayed on the ground that London skill and advice should be obtained, but before this could be had the nobleman died. I do not mean to undervalue London skill, but it certainly is great folly to delay in this complaint."

It is necessary to establish beyond cavil the best emergency operation for the treatment of perforated ulcer, so that there may be no doubt in the mind of any practitioner "of strong mind and who has studied his profession with industry," who may be called upon to deal with this catastrophe.

In any surgical emergency the best method to adopt is that which combines efficiency with quickness and simplicity, and it is only when such a method has proved unsatisfactory in its results that some more complicated procedure should replace it.

The quickest and simplest method of dealing effectively with a perforated ulcer is to close the perforation rapidly, by infolding sutures, and to close the abdomen with or without drainage. For several reasons, the chief being to prevent recurrence and to forestall subsequent cicatrization and pyloric obstruction, the routine performance of a gastric-enterostomy has been added to this method by many surgeons.

This additional step prolongs an emergency operation, may involve infection of the lesser peritoneal cavity, hæmorrhage from the suture line and other post-operative complications, and, therefore, adds considerably to the patient's risk.

We feel sure that an accurate investigation of the post-operative conditions of cases of perforated ulcer is necessary to determine whether the advantages derived from the gastro-enterostomy warrant this risk.

Methods of Investigation.

In this paper an attempt has been made to estimate the relative values of these two more common methods of operative treatment by (a) bismuth meal examinations of patients who have been operated upon for perforated duodenal ulcer, (b) experimental work on dogs, and (c) some investigations on the cadaver.

No attempt was made to estimate the post-operative mortality of cases of perforated ulcer.

Literature.

A full review of the literature is given by Elsworth Eliot.² He concludes that it is safer not to follow the suturing of the perforation by a gastro-enterostomy, unless the repair of the ulcer reduces the lumen of the bowel to such an extent as to interfere obviously with the passage of food. A very rare occurrence, according to Eliot. He points out that the food is liquid when it reaches the duodenum, and he has demonstrated that the duodenum of a cat will resume its normal calibre after two-thirds or three-quarters of its lumen has been excised.

He summarizes the published results of other methods of treatment. Of these, the insertion of a tampon into the perforation has, of late, received some attention. F. Brunner³ collected 15 cases in which this procedure was performed, with only three deaths, but in Petré's⁴ more valuable table of 92 cases, only three of 39 cases treated by tampon recovered, as opposed to 28 recoveries in 61 cases treated by suture. This method must be regarded as a desperate expedient.

Cases published by Morton,⁵ Fenwick⁶ and Mar-noch⁷ prove that simple suture of a perforation seems to be followed by as complete a cure of the affected ulcer as is accomplished by excision. No trace of the ulcer could be found at autopsy, some weeks after the operation.

Shoemaker⁸ and Dablgren⁹ have shown that an added gastro-enterostomy does not necessarily protect against perforation, nor does it diminish the probability of hæmorrhage of co-existing ulcers (Brunner). Crile¹⁰ states that Billings and his associates have shown that gastric and duodenal ulcers may be accounted for by the transmutation of pathogenic bacteria, a conclusion which is favourably received by clinicians.

Investigation of Post-Operative Results.

We received 23 replies in response to letters sent to 34 patients who had been operated upon for perforated duodenal ulcer during the last seven years.

Two of these stated that recovery had been complete, and that the patients were now serving with the Australian Expeditionary Force. The remaining 21 patients presented themselves for examination.

Method.

In order to avoid interference with their ordinary

duties it was necessary to examine these patients in the evening.

Each patient was instructed to come after the ordinary evening meal to the hospital, where a meal consisting of two ounces of barium sulphate in gruel, with milk and sugar, was administered. A Röntgenological examination was then made, and was repeated, if necessary, at intervals.

Enquires were made into the pre- and post-operative history of each case.

Results.

The results of the investigations, which are set forth in the following table, may be summarized as follows:—

Sex.—There were 20 males and one female. The early clinical view of a preponderance of females over males in these cases was shown to be in error (Mayo).

Age.—The age varied from 22 to 55; the majority of patients were between 30 and 50 at the time of perforation.

Duration of Symptoms Before Perforation.

It is often very difficult to obtain an accurate description of the symptoms preceding those of perforation of a duodenal ulcer.

Moynihan states that he is aware that cases are recorded by various observers, in which it is said that no previous symptoms have been present.

He considers that further details of the history are necessary in these cases, since patients, after denying the existence of symptoms, will generally acknowledge that they have had indigestion so long as to have ceased to remark upon it.

Three of our patients stoutly maintained that they had suffered from no symptoms of digestive disturbance until the perforation pain came like a "bolt from the blue." Another patient had suffered from vague abdominal pain for two days only, but the remaining seventeen had experienced vague pain, feelings of distension and similar symptoms for periods varying from three months to sixteen years. It is disheartening to find that the symptoms in these cases did not follow the definite and well ordered sequence described by Moynihan. The pain, for instance, was variable in incidence and in degree, and was not always relieved by food.

The relationship between the chronicity of the ulcer, as determined by the degree of cicatrization, and the duration of symptoms of ulceration prior to perforation is worthy of further investigation.

Operation.

In this series it is fortunate that a fair comparison can be made between the two more common methods of operative treatment.

In ten cases the perforation was treated by simple suture and subsequent closure of the abdomen, with or without drainage.

In eleven cases, in addition to suture of the perforation, a gastro-enterostomy was performed.

The time which had elapsed since the operation varied from six months to seven years.

The results are composed in the following table:—

| Condition of Patient. | Gastro-Enterostomy and Suture, Cases. | Suture, Cases. |
|---|---------------------------------------|----------------|
| Complete Recovery; no post-operative symptoms . . . | 4 . . | 5 |
| Slight symptoms of digestive disturbance | 6 . . | 4 |
| Severe post-operative symptoms and return to hospital . . . | 1 . . | 1 |

Results of Bismuth Meal Examination.

A. Cases Treated by Suture.—There was no pyloric obstruction, as shown by delayed emptying or dilatation of the stomach in any of these cases.

No deformity of the first part of the duodenum could be seen on screen examination.

In some of these cases, particularly those complaining of some digestive disturbance, there was a degree of gastric hypertonus, though this was not so marked as in cases of active duodenal ulceration.

The presence of this hypertonus is to be regarded as a danger signal, indicating that care is necessary to prevent a recurrence of ulceration.

Hyperperistalsis was noted in several cases.

We propose to examine these cases at intervals, in order to determine if the hypertonus and hyperperistalsis increase coincidently with signs of recurrence of the ulcer.

We have heard of a case in which transitory signs of pyloric obstruction were present after suture of a duodenal perforation; but there were no signs of obstruction in our series.

B. Cases Treated by Gastro-enterostomy.—In these cases there was a definite tendency to closure of the gastro-enterostomy opening, and in the majority of cases food was passing through the pylorus more freely than through the anastomosis. The severity of post-operative symptoms appeared directly proportional to the amount of bismuth seen passing through the pylorus, and in the case which had been re-admitted to hospital, the gastro-enterostomy opening had almost closed.

The time since operation is an important factor, for some of the cases operated upon recently, in which the anastomosis was particularly free, may, when re-examined, show signs of contraction and recurrence.

In many of these cases there was some gastric hypertonus, just as was the case in cases treated by suture.

It will be seen that the method of infolding an ulcer is not in itself sufficient to produce permanent pyloric obstruction; a conclusion which is supported by the results in experiments on animals (*q.v.*).

It is only in cases where the ulcer has itself given rise to obstruction by cicatricial contraction that infolding sutures are effective, for they complete an already advanced obstruction.

It is apparently more usual to find that perforation has occurred in an ulcer, which has not given rise to much contraction, though further investigation is required to determine the truth of this statement.

In this class of case, infolding the ulcer does not completely obstruct the first part of the duodenum,

and a gastro-enterostomy, in the absence of this obstruction, is mere waste of time, for our results show that the opening contracts rapidly. The additional risks entailed by the operation are not justified by the results.

No operation gives such a satisfactory result as an effective gastro-enterostomy in cases of complete pyloric obstruction, but it is a very unwise step to adopt in the absence of this complete obstruction.

At the 1914 Surgical Congress at New York, the consensus of opinion favoured gastro-enterostomy and pyloric excision or effective exclusion (*e.g.*, by a living ligature or similar methods) as the best method of treatment of non-perforated chronic duodenal ulcer.

This procedure is obviously too extensive to be employed as an emergency operation. Excision of the pylorus and part of the duodenum would seem a rational step in cases where, after suture of a perforation, signs of ulcer had recurred; but here again post-operative investigation of patients is necessary to determine its efficacy.

Recurrence of Symptoms.

We could not but be struck by the fact that symptoms of digestive disturbance recurred after operation in a large number of our cases, quite irrespective of the type of operation performed. In two cases this recurrence was so severe as to lead to re-admission to hospital.

This is very unsatisfactory, and emphasizes the need for careful examination of these patients at intervals after operation, in order that early treatment of symptoms should be undertaken.

We were unable to determine why some of the patients should have remained quite well, whilst others developed symptoms of recurrence. Here, as in the problem of treatment of duodenal ulcer generally, the lack of knowledge of the aetiology of this disease is the stumbling block.

Measurements in the Cadaver.

An investigation of the circumferences of the alimentary canal in the pyloric region gave the following results:—

| Site of Measurements. | Average Circumference. |
|------------------------------------|------------------------|
| 1 inch proximal to pylorus.. . . . | 2.8 inches |
| Pylorus | 1.8 inches |
| ½ inch distal to pylorus | 2.3 inches |
| 1½ inch distal to pylorus | 1.9 inches |

These measurements are, of course, merely for the sake of comparison, and probably bear no relation to those in the living subject; but they demonstrate that it is possible to diminish considerably the lumen of the bowel immediately distal to the pylorus without causing constriction greater than exists proximally and distally.

(Our thanks are due to Dr. Upjohn for obtaining these measurements.)

Experiment on Dogs.

These experiments were performed in order to determine the degree of obstruction caused by extensive infolding of the duodenum.

Methods.

Four fox terrier bitches were employed for this investigation.

The normal emptying time of the stomach after a meal of lean minced meat, containing two ounces of barium sulphate, was administered. This was found to be very constantly between 3½ and 4 hours.

The animals were anaesthetized with chloroform and ether, and a midline epigastric incision made.

The duodenum, 0.25 cm. distal to the pylorus, was then infolded by three superimposed layers of silk sutures, inserted at right angles to the long axis of the bowel. In this way the ventral surface of the duodenum was invaginated for a distance of 0.75 cm., the cephalic and caudal borders being approximated by the last suture.

The abdominal wound was sutured in layers with catgut. All the animals recovered from the operation without incident.

Results of Post-Operative Bismuth Meal Examination.

A similar meal of lean minced meat and two ounces of barium was administered.

| Dog. | Time After Operation. | Time of Emptying of Stomach. |
|-----------|-----------------------|------------------------------|
| 1 | 3 months | 6½ hours |
| 2 | 3 months | 6 hours |
| 3 | 2½ months | 6 hours |
| 4 | 2½ months | 5 hours |

It will be seen that the complete emptying of the stomach was delayed, but that this delay was not very marked. It could not be said that the pyloric obstruction was considerable.

Post-Mortem Appearances.

There was scarring at the site of infolding, which appeared to cause more obstruction than was demonstrated by bismuth examination or later by section of the gut.

It is evident that it is difficult to form an accurate estimate of the degree of obstruction caused by a duodenal cicatrix by an inspection of its superficial surface.

Though we have as yet finished only a small series of experiments, our results are fairly uniform, and prove that extensive infolding of the duodenum in the dog fails to produce severe obstruction.

Conclusions.

It is unwise to draw dogmatic conclusions from this limited series of cases, and we propose therefore to continue and to extend this investigation.

Our results at this stage fail to justify the performance of a gastro-enterostomy as a routine treatment of perforated duodenal ulcer, and may be summarized as follows:—

1. The post-operative results of cases treated by suture and gastro-enterostomy are no better than those cases treated by suture alone.

2. There is considerable experimental and clinical evidence to disprove the efficacy of infolding sutures in producing permanent pyloric obstruction.

3. In the absence of such obstruction, the performance of a gastro-enterostomy is unjustifiable. The anastomotic opening displays a marked tendency to contract and become functionless.

4. The ordinary methods of surgical treatment of duodenal ulcer frequently fail to give permanently satisfactory results, and it is necessary to observe these cases at intervals after their discharge from hospital.

5. The best routine treatment of perforated duodenal ulcer is to operate at once, to close the perforation by infolding sutures, and to close the abdomen as rapidly as possible, for, in the words of Sir Astley Cooper, "it certainly is great folly to delay in this complaint."

Exceptional cases must be treated as seems best at the time, but to lose a case of perforated duodenal ulcer, in which he has performed a gastro-enterostomy, must give the surgeon "furiously to think" how far this extra step was responsible in causing the death of his patient.

References.

- ¹ Sir Astley Cooper—*Lectures on Surgery*, E. Portwine & Co., London, 1835, p. 211.
- ² Elliot—*Annals Surgery*, Part 232, p. 546; Part 233, p. 689.
- ³ Brunner—*Deutsche Zeit. f. Chirurg.*, 1903, 69.
- ⁴ Petró—*Beitrag z. Klin. Chir.*, 1911, II., LXXII., 319.
- ⁵ Morton—*Med. Press and Circ.*, 1909, XLIV., p. 863.
- ⁶ Fenwick—*Brit. Med. Journ.*, 1910, I., 443.
- ⁷ Marnoch—*Brit. Med. Journ.*, 1909.
- ⁸ Shoemaker—*Mitt. a. d. Grenzgeb. d. Med. u. Chir.*, 1909, XX., 21.
- ⁹ Dahlgren—*Nord. Med. Arkiv.*, 1908, XLI., Ht. 3, Nos. 11-12 (3-9 quoted by Elliot).
- ¹⁰ Crile—*Brit. Journ. Surg.*, 1914-15, p. 682.
- ¹¹ Moynihan—*Duodenal Ulcer*, Saunders & Co., 1910.

THE PASSAGE OF FOOD THROUGH THE STOMACH AFTER PÓLYA'S GASTRECTOMY.¹

By C. E. Corlette, M.D., Ch.M., D.P.H.,
Surgeon, Sydney Hospital.

Pylorotomy is now usually accompanied by transverse resection of the stomach reaching from a point high up on the lesser curvature, near the œsophageal opening, down to some selected point on the greater curvature. It is done either for cancer, or as a preventive operation when a chronic ulcer, a pre-cancerous lesion, endangers the patient's future in the same way. The method most commonly used at the present time is to resect and sew up the line of section across the stomach and subsequently perform a gastro-jejunostomy, or in some cases the gastro-jejunostomy is carried out first and the resection dealt with afterwards. The residual portion of stomach is often so exiguous as to make it very difficult to do a satisfactory gastro-jejunostomy, and since the blood supply of the stomach in the area just to the right of the anastomosis has been interfered with, it is not quite so safe as in a non-resected stomach. Another method of completing a gastrectomy devised by a Hungarian surgeon named Pólya, some years ago, has attracted attention as an attempt to shorten and simplify the operation. The technique employed is to implant the cut end of the stomach into the side of the jejunum instead of sewing it up, the complementary second operation being thus avoided altogether. From the point of view of technique Pólya's is a good operation. Time and experience will show whether it gives as good after-results as the other

method. Dr. J. G. Edwards has kindly studied the passage of a bismuth meal in a patient recently under my care, about ten weeks after a gastrectomy for malignant disease completed by Pólya's method. His report is particularly interesting, as the operation has not been performed in a large number of cases up to the present, and observations of the kind must necessarily have been few.

Three observations were made. It was found that the bismuth passed down from the œsophagus into what looked like a tubular stomach nearly vertical in position, where it remained for no more than two or three minutes, and then passed out into the small intestine in the left iliac region. The stomach capacity was small, and the total amount of bismuth retained in it at any one time was small. It was, therefore, difficult to make the examination as searching as it would be with a slower passage and greater accumulation of bismuth in the viscus.

It is evident from the result of this examination that the stomach, or what is left of it, had become little more than a prolongation of the œsophagus. In effect, the patient feeds himself through a jejunostomy, the opening of which is internal, and adjusted to receive food directly swallowed, instead of being in the abdominal wall with an external opening, by which food may be introduced through a funnel and tube.

Having regard to the high section of the stomach on the lesser curvature, close to the œsophagus, the position of the stoma as seen in the upright position was rather lower than I expected, but our conceptions of anatomical position, gained in the first instance from examination of organs in a body lying in the dorsal position, are subject to considerable alteration in the erect position as shown by radiography, and often more than we expected. In performing Pólya's operation, a loop of jejunum, as close to its origin as is conveniently possible, is brought up through a hole made in the transverse meso-colon. After the end of the stomach has been joined to the side of the jejunum, the site of union is drawn down again through the hole, and the edges of the rent are sutured to the walls of the stomach proximal to the junction, so that the stoma lies below the meso-colon, and more or less beneath the transverse colon. In the erect position, this is, after all, not such a long way above the left iliac region. It would seem, nevertheless, that the portion of lesser curvature between the œsophageal opening and the gastric artery, where the section is made, may elongate very considerably after such an operation.

I would like to add a few words more to this report. The man, who is 47 years of age, is quite comfortable; he has a good appetite, and takes small, but frequent meals. Further, he has an excellent chance of complete cure, because the disease was attacked in its earliest stage. He was sent up by Dr. Hamilton Marshall, who recommended him for an exploratory operation, a bismuth meal having shown that there was some pyloric obstruction. Malignancy was not diagnosed for certain, even after opening the abdomen. The main reason for resection was that there was a very hard, large, and

¹ Read at a meeting of the New South Wales Branch of the British Medical Association on October 8, 1915.

greatly thickened chronic ulcer at the pylorus in a man at the cancer age of life. There was only one moderately enlarged gland. Microscopical examination afterwards showed malignancy in the ulcer, but not in the gland.

This is the second time I have resected on suspicion, and the microscopical examination has shown the ulcer to be cancerous, but the glands free. And both patients have done well.

The time to operate in order to save cases of malignant disease of the stomach is before a clinical diagnosis is made, not after. A bismuth meal examination is of the greatest possible value in deciding whether there is any likelihood of organic disease of the stomach being present.

Reports of Cases.

APPENDICITIS IN A PATIENT WITH CAECUM AND ASCENDING COLON ON THE LEFT SIDE.¹

By C. E. Corlette, M.D., M.Ch., D.P.H.,
Surgeon, Sydney Hospital.

W.F.B., æt. 42 years, was seen August 18, 1915, in consultation with Dr. Luker, as a case of suspected appendicitis. His temperature was normal, pulse rate 96, and there was pain and tenderness referred to McBurney's point, and also a little higher. The pain had come on suddenly 24 hours previously, and had been severe all night. There had been no vomiting.

Appendicitis was diagnosed, and an operation was performed the same day. The usual McBurney's incision was made and the abdomen opened, but on searching for the appendix it could not be found, nor could any sign of caecum or ascending colon be felt. The right side of the abdomen was entirely occupied by small intestine. The incision was then closed and a median opening made through which the abdomen was explored. It was found that the caecum and ascending colon were situated on the left side, in immediate contact with the descending colon, the transverse colon, and omentum being absent. The appendix was long, swollen, and inflamed, and attached by a long meso-appendix. The caecum and ascending colon were furnished with a meson presenting a free border at the brim of the pelvis, and attached up and down the middle line in front of the vertebral column, close to the aorta. The ileum entered the left side of the caecum as usual, but came up towards it from below and to the right. I did not actually feel for the site of origin of the jejunum, but there was certainly no intestine seen to the left of the caecum, except the terminal inch or two of the ileum, and the mesentery must have been wholly to the right of the caecum and ascending colon. It seems probable, therefore, that the jejunum, at its origin, was either to the right of or beneath the colonic meson.

The congenital abnormality which I have here described is certainly an extremely rare one. I have never seen it before, in over 20 years of hospital experience, but I have seen cases more or less resembling it recorded. It acquires a good deal of surgical importance from the difficulties and surprises it is likely to provide if appendicitis occurs, as it did in this case. It would be a very disconcerting condition for anyone to meet, and especially for a young and comparatively inexperienced operator, and it might easily lead to an abandonment of the operation, with an untouched appendix.

It is worthy of note that in this patient, although his appendix was placed on the left side, yet both the pain and the tenderness were referred to the usual spot on the right side. On the other hand, I have seen many cases of appendicitis down in the pelvis, in which the pain and tenderness were diffused in the hypogastric region, with little or no localization at McBurney's point.

Postscriptum.—Since the above was written, the October number of *Surgery, Gynaecology and Obstetrics* (Vol. XXI, 1915, p. 442) has come to hand. It contains an article by Joseph H. Schrup on "Left-sided Appendicitis," in which he describes a case of his own, closely resembling mine. In this case, too, there was tenderness over McBurney's point, but at the operation there was no appendix, caecum, or ascending colon in the usual situation. The jejunum was coiled up in the right half of the abdomen, in the customary position of the caecum and ascending colon. The caecum was over on the left side, adjacent to the sigmoid. An X-ray picture taken later on showed distinct angulation at the splenic flexure, with the absence of the transverse colon and omentum, while the caecum and ascending colon were in close apposition to the descending colon and sigmoid. Schrup has collected from the literature descriptions of two other instances of similar anomalies, one by Cabot, Boston (*Med. and Surg. Journ.*, 1836, XLVI., 70), and the other by Cluëne (*Journ. Anat. and Physiol.*, Lond., 1867, ii., 14).

Reviews.

PHILOSOPHY.

The difference between the beliefs and opinions of an old medicine man,¹ and stereotyped philosophy is as great as the proverbial difference between chalk and cheese. If you are hungry, chalk is not satisfying; while, if you wish to teach a class of school children, you will not find cheese a good agent for reproducing symbols on the blackboard. But, while there may be but little resemblance between the attempt to analyse life biologically, chemically or inductively, and the achievement of jotting down ideas which have evolved in the course of a lifetime, both are deserving of the term of philosophy, provided that both are serious attempts to discover truth. The book before us contains much that is scrappy, much that will not be accepted by the thinking person, and much that may even deserve the description of intelligent nonsense. But it also contains much of great interest. The ideas are depicted in a manner which compels us to enquire whether the truth does not lie within the meaning of the writer, and whether it would not be profitable to adopt within limitations similar methods of reasoning. The author declares himself a rationalist, with marked tendencies and sympathies for dogma. His sympathy does not prevent him from refusing some of the most cherished dogmas of the present and of the past. But he is inclined to retain dogmas in a most contradictory spirit; more especially those dogmas which the modern materialist spurns without a second thought. The book is readable; it should be read carefully; and, if read once, some parts should be read again. The author does not trouble himself to arrange his material to suit the convenience of his reader. The parts which one man will ponder over may not attract another. Consequently, he has thrown all his ideas into a sac, and has left it to others to select what they please.

The first part is said to be partly personal. He is consistent in recognizing that everything reverts to the *ego*, and, consequently, he is not afraid of devoting the greater part of the small publication to impressions, ideas and experiences which are, as he terms it, partly personal. He does not solve the hereafter or the essence of life. He does not even attempt to. He conceives a healthy aspect of life, in that he denies that man is the favourite of the Creator, and that any creature is. He recognizes that the individual is never more than a mere unit, and that exceptions to the laws of nature cannot under any conceivable circumstances be made in his favour. He develops pantheistic arguments in regard to the Divine Intelligence and mankind, in regard to death and the present position of man to his environment. But he becomes almost rigidly materialistic in dealing with the occult, and with the interdependence of religion and sex. But when he picks up the thread and alights on the subject of superstitions, he undergoes metamorphosis, and has the courage to admit fear, which is the basis of superstition, for himself and for the vast majority of mankind. In the chapters devoted to this subject and to

¹ Read at a meeting of the New South Wales Branch of the British Medical Association on October 8, 1915.

¹ *Religio Medici Moderati, Being the Beliefs and Opinions of an Old Medicine Man*, by Neo Kama, M.D., 1915. London: John Bale, Sons & Danielsson, Ltd.; Demy 8vo., pp. 118. Price, 2s. 6d.

faith, hope and charity, he succeeds in annoying and pleasing, in awakening wonder and in arousing interest, in stimulating opposition and in eliciting agreement. He is less delightful when he turns his attention to ambition, prayer, aspiration and morality, but even here we meet with the expressions of opinion of an intelligent, thinking man of the world, who has seen much, thought much, and analysed it all. Read it!

HUMAN ANATOMY.

As a rule, the number of editions of any given publication may be regarded as an index of its excellence, more especially in regard to books on scientific subjects. There are exceptions, however, to this rule. We have come reluctantly to the conclusion that "Potter's Compend of Human Anatomy"² is one of these exceptions. The author calls attention to the fact that the book has been written for the use of medical students preparing for examinations. He has, therefore, confined himself to what he terms essentials. We find, however, that these essentials are often not in conformity with the accepted teaching of anatomy. For example, the description of the brachial plexus is quite inaccurate, and would, if written by a candidate at an examination, lead to his failure. There are numerous other errors, such as the statement that the flexor carpi radialis is inserted into the base of the metacarpal bone of the index finger, and that the tendons of the palmaris longus and flexor carpi radialis are inserted into the anterior surface of the anterior annular ligament.

The diagrams, illustrations and general contents of the book savour of a desire on the part of the author to adopt those methods usually known as cramming.

The author holds the view that many of the B.N.A. terms are inconsistent, and are doomed to disappear, and he has therefore utilized only those new terms which appear to him to be preferable to old terminology. It is with regret that we cannot bring ourselves to recommend this book to medical students.

Hospitals.

ST. VINCENT'S HOSPITAL, MELBOURNE.

The Annual Report of the St. Vincent's Hospital, Melbourne, to which reference has already been made (see *The Medical Journal of Australia*, November 6, 1915, page 447), contains a general account of the activity of the Order of the Sisters of Charity, with special reference to the Hospital. This is followed by an appeal for a million shillings for the extension of the hospital to increase the accommodation by 150 beds.

During the year, as a result of the special effort of the Ancient Order of Druids, a building known as the Druids' Wing was taken over for out-patient work. A description of the spacious central hall, with its surrounding corridors and numerous rooms for general and special examination, with dressing rooms, bathrooms, etc., is given. It appears that the Out-Patient Department of St. Vincent's Hospital is a very large and busy portion of the institution. It is the habit of some hospitals to advertise the number of out-patients attended to in order to stimulate the community to subscribe to the funds. An excessively large out-patient department carries with it marked disadvantages. The community does not reap any benefit when the treatment is applied wholesale, and each patient is given only a minute or two. For this reason we hold the opinion that the appeal of the Sisters of Charity would be stronger if it depended on the good work carried out within the wards of the Hospital. In the Druids' Wing the two upper floors provide accommodation for 64 nurses. Each nurse has a separate room, in which hot and cold water is laid on, as well as electric light. On each floor there is a sitting-room, a library and a general lounge, while a roof garden provides room for recreation for the nurses.

The St. Vincent's Hospital contains a Training School for Nurses. Since its establishment in 1892 172 nurses have qualified, and are either employed within the hospital or

engaged in nursing practice outside. In the Pathological Department the equipment and facilities enable the Pathologist and his staff to accomplish excellent work.

Short paragraphs are appended on the work of the special departments.

On April 18, 1915, an official ceremony took place on the occasion of the visit of the Apostolic Delegate, his Excellency the Most Reverend Dr. Cerretti. A guard of honour consisting of medical students was formed.

The balance sheet shows an ordinary income of £12,450, including a Government grant of £3,600, municipal grants of £250, and various contributions, etc., making up the remainder. The bequests during the year amounted to a little over £1,000. On the other side the expenditure exceeded the income by £1875. The bank overdraft has consequently been increased from £1376 to £3,251.

The medical report of the hospital contains a table of the various cases of illness and accidents treated, a statistical report and a list of operations. The information in the first is divided into medical and surgical. We would suggest that the professional work of the hospital should receive more detailed attention in the annual reports, in order that the records might be used for various statistical and other purposes. From the table it is possible to ascertain the case mortality of the various diseases treated, as well as the frequency of the same. It appears that there were 109 cases of lobar pneumonia, with 19 deaths, which is equal to a case mortality of 17.4. Enteric fever was treated 53 times, and 3 of the patients died. This gives a case mortality of 5.6. It appears that 47 patients suffering from acute rheumatism were treated. All of them recovered. That the case mortality as revealed by the proportion of deaths to total cases cannot be relied on under all circumstances, is instanced in the case of tumour of the brain. There were two cases of this disease; both patients were discharged, and therefore the mortality would appear to be nil. On the same basis, the case mortality of cerebral abscess would appear to be 100%, that of cerebro-spinal syphilis nil, that of suppurative meningitis 50%, that of *myasthenia gravis* nil, that of cerebral hæmorrhage 54.5%, and that of ulcerative endocarditis nil.

The last chapter of the report deals with the opening ceremony of the Clinical School. It appears that the account of the opening of the Southall Wing was prepared for inclusion in the report for the year ending June 30, 1910, but was omitted at the special request of Mrs. Southall. As Mrs. Southall has recently died the report is now published. The ceremony took place on March 20, 1910. Speeches were made by Dr. Murray Morton (Chairman of the Medical Staff), Sir John Madden (Chancellor of the University), Professor Allen (Dean of the Faculty of Medicine), Mrs. John Southall, Dr. A. Norman McArthur (Senior Gynaecologist to the Hospital), and the Honourable J. Gavin Duffy, K.S.G.

THE BRISBANE GENERAL HOSPITAL.

According to the published report of a committee meeting held at the Brisbane General Hospital on November 3, 1915, the subject of the relations between the resident medical staff and the military authority received attention. It appears that a suggestion has been made that the Hospital Committee should confer with the Department of Defence with a view to determining what calls the latter should make on the members of the resident medical staff. Lieutenant-Colonel McIntosh, Principal Medical Officer of the 1st Military District, has expressed his appreciation of the manner in which the staff of the hospital carried out the nursing of sick soldiers prior to the embarkation of the troops. He has also informed the Department that the hospital would be placed in a very serious position if the members of the resident medical staff were called upon to undertake military duty with the forces, and has urged the Deputy Director-General of Medical Services not to drain the resources of the hospital in this respect.

Among the nominees of His Excellency the Governor for the positions of Members of the Board of Governors of the Public Library, Museum and Art Gallery of South Australia is Dr. R. S. Rogers. The University of Adelaide is represented by Professor W. J. Brown and Professor G. C. Henderson. The Board consists of 14 members,

² Potter's Compend of Human Anatomy, by D. Gregg Metheny, M.D., L.R.C.P., L.F.P.S., 1915. Philadelphia: P. Blakiston's Son & Co., pp. 428, demi 8vo. Price, \$1.

The Medical Journal of Australia.

SATURDAY, NOVEMBER 27, 1915.

The Medical Practitioners Amendment Act, 1915

In the New South Wales Government *Gazette*, No. 206, dated November 17, 1915, the announcement is made that his Excellency the Governor, in the name and on behalf of His Majesty, had assented, on November 10, 1915, to certain Acts passed by the Legislative Council and Legislative Assembly of New South Wales in Parliament assembled, including Act No. 33, 1915, "An Act to amend the 'Medical Practitioners Act, 1912.' " An account of the debates in the two Houses, together with the text of the original Bill and of the amendments proposed and those agreed to, will be found in *The Medical Journal of Australia* of October 30, 1915, pp. 430-432, November 6, pp. 453-455, and November 13, pp. 476-478. The measure as presented to the Legislative Assembly was a simple and direct one. The Minister, in introducing it, pointed out that it was an emergency measure, primarily designed to enable certain graduates in medicine to be registered in order that they might "take their places in the military forces." To effect this, it was proposed to alter the law so that a graduate in medicine of an Australian University, or of a University of Great Britain or Ireland, or a diplomate of one of the corporate colleges of physicians or surgeons in Great Britain or Ireland could be registered without any restrictions or conditions. The second sub-clause required a five years' course and a diploma or degree, entitling the holder to practise in the country in which the diploma or degree had been granted, for all medical practitioners other than those mentioned in the first sub-clause, licentiates of the Society of Apothecaries and duly appointed and confirmed medical officers in His Majesty's land or sea forces.

The alteration of the law in regard to the first provision is eminently satisfactory. Hitherto graduates of the Sydney University, and indeed of the Universities of the Commonwealth have suffered

an injustice as compared with graduates of the Universities of Great Britain and Ireland. While no restriction was imposed in regard to the latter, the course was rigidly fixed at five years by law in regard to the Australian universities. The amendment places the graduates of our excellent universities on an equal footing with the holders of degrees of other universities, and the progress of the past 33 years is thus recognized in a satisfactory manner. The public has learned to have confidence in the teaching at the Sydney, Melbourne and Adelaide Universities, and it is meet that in setting up a list of those who should have a right to be registered, the first place should be given to our own graduates.

The second sub-clause was introduced because the same provisions were included in the Act of 1912. This sub-clause has been regarded as unsatisfactory by the members of the medical profession for many years, and it should have been evident to those responsible for the drafting of the measure that its amendment was desirable. As events have proved, the smooth passage of the bill was risked in order that this clause might be made more acceptable to the Legislature and to the community. In the form in which the amended sub-clause eventually emerged two means are included for the protection of the public against the introduction of undesirable practitioners. While it is hoped that other safeguards will be enacted at some future date in regard to those within the Commonwealth who fail to uphold the honour and dignity of the medical profession, it is eminently satisfactory that the admission of foreign practitioners should be based on a definite footing. The first safeguard is the recognition of the principle of reciprocity. Virtually, the clause prohibits a foreign graduate from being registered in New South Wales without passing an examination. The same applies to the New South Wales graduate in regard to foreign countries, and consequently the enactment is equitable. The second safeguard takes the form of requiring foreign practitioners to pass an examination prescribed by the University of Sydney. This provision may or may not be made use of. But it offers to foreign practitioners more than the foreign States offer to Australian practitioners, with one notable exception. The control, however, lies in the hands of the

University, and it is unlikely that this registration examination will be an easy one, which an undesirable practitioner could pass without effort. In the last place, the law as it stands excludes without exception all German or Austrian subjects. After some difficulty this part of the clause has been worded in such a manner that no second meaning could possibly be read into it.

OPTICIANS, OCULISTS AND SCHOOL CHILDREN.

A matter of considerable moment was dealt with in the Legislative Assembly of New South Wales on November 2, 1915. The questions and replies concerning the vision of school children will be found in last week's issue. These questions embraced a number of separate problems, and, judged from the tone adopted by all of the speakers save Dr. Arthur and Captain Toombs, it would seem that the significance of the various matters has not been appraised correctly. The first matter appears to be one of urgency as well as importance, since Mr. Griffith referred to the fact that a Bill to regulate and control opticians was now on the business paper. The second point concerns itself with the question as to who should undertake the task of prescribing glasses for school children found, at the school inspection, to have defective vision. Incidentally, the point was raised as to whether these children should be taken to hospitals for the purpose, and lastly, the remarks of Mr. Griffith contained reference to the treatment of cases of extreme myopia in school children. We propose to return to these various subjects within a short time, and for the present to restrict our remarks to the point first mentioned.

A Bill providing for the registration of opticians has been introduced from time to time in Queensland. This Bill found its way some years back to Tasmania, and unfortunately has become law in the latter State. In England a Bill, originated by the Spectacle Makers' Company and other bodies, acting in the interests of certain sections of opticians, was introduced into the House of Lords in 1906, by Lord Addington, but was impeded by the General Medical Council, the British Medical Association, and the Ophthalmological Society of the United Kingdom. Furthermore, the Eye and Ear Section of the

Victorian Branch of the British Medical Association published, in the year 1911, an excellent report in opposition to the proposed recognition of opticians. The arguments against the creation of a specially-privileged class of persons to carry on a certain branch of medical work, namely, the testing of eyesight, are so forcible and so numerous that it may be claimed that no open-minded legislative body could oppose them, more especially because they emanate from those best qualified to speak with authority. The chief objections put forward may be repeated in this place. Should any further progress be made with the New South Wales Bill or with a similar bill in any other State, it may be deemed advisable to reproduce the statements published by the bodies enumerated above.

The opticians claim that they are competent to test eyesight and to prescribe glasses for errors of refraction. It can be shown that the defects producing myopia, hypermetropia and presbyopia are not merely physical defects which can be corrected in a mechanical manner by a maker of lenses. The eye is a living organ, and is a nervous organ. Unless the treatment of abnormalities be undertaken by skilled persons, who have a full knowledge of the physiology of the human body, and of the diseases which affect the body, safety cannot be guaranteed. In the second place, it is at times impossible to determine the error in refraction without the use of a mydriatic. Opticians are not allowed to instil atropine or other drugs of this class into an eye, and they are consequently restricted in the testing of the eyesight. No more absurd position could be imagined than to grant registration to persons without medical training as being qualified to test eyesight and at the same time to refuse to allow the registered persons to use the essential means of examination. On the other hand, no one would suggest that opticians should be allowed to use mydriatics. It is therefore correct to describe a bill of the kind under discussion as "misleading and dangerous to the public." In the third place, the knowledge of the optician is insufficient to enable him to distinguish errors of refraction from eye symptoms of disease processes, and endless damage can be done by the prescription of glasses in certain pathological conditions associated with eye symptoms.

The President of the General Medical Council is therefore justified in stating that "to confer on the optician the privilege of himself prescribing for and treating patients suffering from disorders of the eye would be to sanction the creation of an inferior and purely commercial order of medical practitioner, exempted from the training and the disciplinary restraints which the Medical Acts impose."

THE SHORTAGE OF NURSES.

For some little time past special endeavours have been made to meet the position created by the demand for nurses to serve with the troops. The matter has occupied the attention of the Royal Victorian Trained Nurses Association in Melbourne, and of the Victorian Branch of the British Medical Association. The steps adopted to create a supply equal to the demand have been recorded in the columns of *The Medical Journal of Australia* (September 25, 1915, page 302; October 30, page 426, and November 20, page 498).

In regard to the Australasian Trained Nurses' Association, it appears that there are 3,150 names on the register, but inasmuch as several of the nurses have relinquished practice since registering, the total number of available nurses is probably between 2,800 and 2,900. Since the beginning of the war 574 members of the A.T.N.A. have left the Commonwealth for duty with the forces. Of this number 330 are on the New South Wales register, 112 on the Queensland register, 48 on the South Australian register, 53 on the Western Australian register, and 31 on the Tasmanian register. Approximately 200 members of the Royal Victorian Trained Nurses' Association are at the front. This means that approximately 800 registered general nurses have given up hospital and private work in the Commonwealth for military duty abroad. The nursing profession has been depleted up to the present to the extent of about 20% of its members. The Defence Department has called for reinforcements at the rate of 90 per quarter. Thirty of the nurses will be recruited in Victoria, a similar number in New South Wales, and the remainder in South Australia, Queensland, Western Australia, and Tasmania.

In thus appears that the requirements of the Department of Defence have produced a distinct shortage of nurses for hospital and private practice. In many of the registered private hospitals in Sydney the staff has been reduced by about 25%. In the large public hospitals not only has the number of the nurses decreased but the proportion of junior nurses has been very greatly increased. We are informed that the Matrons of many of the country hospitals are on duty abroad, and have been replaced with difficulty. In many instances the appointments are temporary. Still greater difficulty has been experienced in procuring the services of capable substitutes for head nurses at country hospitals, in view of the fact that these nurses are required to take charge of the hospital in the absence of the matron.

The Australasian Trained Nurses' Association has recognized that the interests of the majority of the nurses on active service abroad must be safeguarded in order that when they return they will find work to do. On the other hand, special means were required to meet the pressing necessities of the moment. The Council has therefore permitted nurses training in schools with a 4 and 5 years' course to present themselves for examination earlier than usual. An extra examination was held in September, and 50 nurses have been placed on the register. Other means of increasing the local supply of registered nurses are being considered. In another column will be found an account of the proposals put forward by the Australasian Trained Nurses' Association at a conference with the military authority.

We have been informed that the Bush Nursing Association has been obliged to employ nurses with obstetric certificates, and only a partial general training. These nurses are not eligible for military service. The expedient is a temporary one.

THE SUSPENSION OF TRADE MARKS.

The Federal Government has determined to suspend all trade marks of enemy goods, save those manufactured by British workmen or in the countries of our Allies. Articles manufactured under the licence of the Commonwealth and under official supervision may, however, be sold for a limited period with an announcement on the label that the new preparation is the equivalent of the proscribed article. For example, the drug aceto-salicylic acid is sold as aspirin. Certain firms have introduced the same substance under various protected names. It will be permissible for these firms to append on the labels of the substitutes a statement that the article is aspirin under a new name. As soon as the public has become acquainted with the fact, the word aspirin must disappear. The Commonwealth authorities reserve for themselves the right to coin the substituted name, or, alternatively, to approve a suggested name. There are several objections to the whole manner of dealing with this matter. In the first place the public does not derive any benefit from the facile sale of strong and often dangerous drugs. The introduction of compressed tablets under various patented terms has tempted the public to dose itself without a satisfactory diagnosis in a manner and to a degree which is akin to courting danger. There is no objection to the sale of simple aperients, but the practice of placing narcotics and powerful sedatives within the reach of the community is, in our opinion, fraught with risk. Consequently, we fail to see the value of teaching the public the substituted names for aspirin or other patented preparations. To the medical profession, the chemical terms should be sufficient. Pure aceto-salicylic acid does not vary, because it is made by a firm of manufacturers, who sell it in this or that form. The term aspirin is redundant; and so are the substituted names. Moreover, the same drug would be sold at a lower cost if these fancy names were prohibited altogether, since, by competition, the manufacturers would have to be content with

comparatively reasonable profits, lest their competitors wrested the sale from them. If the medical profession united in demanding and insisted on obtaining drugs labelled according to their chemical nomenclature, or, in the case of unwieldy compound terms, by an abbreviated chemical term, and if all protected special preparations of these drugs were persistently refused, we should insure a supply of reliable drugs at a lower cost than hitherto. Incidentally, the necessity of special regulations to prevent enemy firms from profiting directly or indirectly from the sale would be removed.

Naval and Military.

The following has appeared in the *Commonwealth of Australia Gazette*, No. 143, under date of November 18, 1915:—

1st Military District.

Australian Army Medical Corps Reserve—

James Inglis Robertson, Archelaus James Opie, John Gerald Lentaigie and Jack Mowbray Thompson to be Honorary Captains.

George Parker to be Honorary Lieutenant.

2nd Military District.

Australian Army Medical Corps—

Norman Zions and Frederick Clissold Curtis-Elliott to be Captains (provisionally and temporarily).

Major R. Dick is transferred to Supernumerary Establishment.

Captain P. Lalor is transferred to Australian Army Medical Corps, 3rd Military District, with seniority as from date of transfer.

Captain W. W. Martin is transferred from Australian Army Medical Corps Reserve, and to be Captain (provisionally and temporarily).

Australian Army Medical Corps Reserve—

Eric Sinclair and Wahab McMurray to be Honorary Majors. (This cancels the notification respecting these officers which appeared on page 2452 of *Commonwealth of Australia Gazette*, No. 116, of 25th September, 1915.)

William Odillo Maher, Henry Martin Doyle, Edwin Andrew Brearley, George Edward Rennie and Francis Antill Pockley to be Honorary Majors.

John Alexander Watt, Edward Feilchenfeld, Panieri Belli, Edwin Cuthbert Hall, Samuel Boake, Leslie Halse Rogers, John Gray, Thomas Sydney Davies, Trevor Armstrong Turner, Arthur James Partridge Chapman, Herbert Gordon Humphries, Esca Morris Humphrey, Gaetano Alagna, and George Lawson Kerr to be Honorary Captains.

James Wrentmore Cooke, Montague Alfred Noble, Maxwell Sedgwick Allan, Keith Cecil Theodore Sutherland, John Robert Durham, Septimus Edward Paterson, Charles Hepburn Bell, Walter Laurie Younger, Charles Thomas Hunt, Sims Lever, Thomas Gordon Hall, William Goodman McKern, Cecil Boyes York Norton, William Henry Algernon Pye, Robert Bernard Job, Guy Brougham Chapman, Leslie Bruce Hart, Byron Brace Ruse, Edwin Henry Bestic, Henry Beswick Green, William Reginald Morris, William Augustus Starkey, Ernest Feild Deck, Kenneth Younger Kerr, Leslie George Stockwell, and Howard Robinson Greenwell to be Honorary Lieutenants.

3rd Military District.

Australian Army Medical Corps—

Captain P. Lalor is transferred from Australian Army Medical Corps, 2nd Military District, with seniority as from date of transfer.

Australian Army Medical Corps Reserve—

Sidney Valentine Sewell to be Honorary Major.

Leslie Scott Latham to be Honorary Major. (This cancels the notification respecting this officer

which appeared on page 1797 of *Commonwealth of Australia Gazette*, No. 108, of 11th September, 1915.)

John Fullarton MacKeddie to be Honorary Major. (This cancels the notification respecting this officer which appeared on page 2453 of *Commonwealth of Australia Gazette*, No. 116, of 25th September, 1915.)

Henry Laurie, Mathias Michal Perl, Robert James Loosli, James Amess, Norman John Mackay, Harvey Sutton, John Stewart Merrillees, and Robert Edgecumbe Short to be Honorary Captains.

Horace Ernest Stevens, Oscar Behrend, Edwin James Wise, Kenneth Russell, Charles Ernest Allen, Robert Adrian Wright, Norman Edmund Lockhart, Charles Thomas McKinley, and Leslie Norman Roebuck to be Honorary Lieutenants.

4th Military District.

Australian Army Medical Corps—

William David Kerr MacGillivray, George Henry Sawted Dobbyn, and John Gilbert Mackay to be Captains (provisionally and temporarily).

Australian Army Medical Corps Reserve—

Henry Marco James Halloran, Fred William Waters, and Herbert Algar Sweetapple to be Honorary Captains.

5th Military District.

Australian Army Medical Corps Reserve—

Major J. W. Hope is transferred from Retired List, and to be Honorary Captain (temporarily).

Morgan Richards, Charles William Tuthill Woods, and Henry St. John Mitchell to be Honorary Captains.

Gosta Linderstam, Gustave Thomas Donovan, William George Wynne, Frank Southee, Hayward Arthur Cooke, and Harry Reginald Day to be Honorary Lieutenants.

6th Military District.

Australian Army Medical Corps Reserve—

Herbert William Sweetnam to be Honorary Captain. Harold Bisell Henley to be Honorary Lieutenant.

The distribution of the Military Forces in the 2nd Military District has been published in a District Order, No. 117, dated November 20, 1915. The following entry is made under the heading—

| AUSTRALIAN ARMY MEDICAL CORPS. | | | |
|--------------------------------|-----------------|--|----------------|
| Brigade Area. | Battalion Area. | Units and Localities. | Remarks. |
| 4 | 16 | 25th A.A.M.C. (Light Horse Field Ambulance), Newcastle | 2nd L.H. Bgde. |
| 11 | 41, 42 | 26th A.A.M.C. (Light Horse Field Ambulance), Richmond | 3rd L.H. Bgde. |
| 4 | 15, 16 | 4th A.A.M.C. (Field Ambulance), Newcastle | |
| 5 | 17, 18, 19, 20 | 5th A.A.M.C. (Field Ambulance), North Sydney | |
| 6 | 21, 22, 23, 24 | 6th A.A.M.C. (Field Ambulance), East Sydney | |
| 7 | 25, 28 | 7th A.A.M.C. (Field Ambulance), Sydney | |
| 8 | 29, 30, 31, 32 | 8th A.A.M.C. (Field Ambulance), West Sydney | |
| 9 | 33, 34, 35 | 9th A.A.M.C. (Field Ambulance), Western Suburbs | |
| 10 | 39, 40 | 10th A.A.M.C. (Field Ambulance), Ashfield | |
| 11 | 43 | 11th A.A.M.C. (Field Ambulance), Goulburn | |
| 8 | 29, 30, 31, 32 | 39th A.A.M.C. (Company), West Sydney | |
| 9 | 33, 34, 35, 36 | 40th A.A.M.C. (Company), Western Suburbs | |

PRINCIPAL MEDICAL OFFICERS.

Our attention has been directed to an obvious error contained in the letter signed by Lieutenant-Colonel Dodds, dealing with the new regulations governing the appointment of the Principal Medical Officers of the 2nd and 3rd Military District (see *The Medical Journal of Australia*, No-

ember 13, 1915, p. 469). In the eighth paragraph of the letter it is stated that the applications would close on November 29. In the advertisement calling for applications, the last day for receiving the same was given as November 20. On enquiry, we learn that the date November 20 was correct, and that the date mentioned in the letter was in error.

THE SHORTAGE OF NURSES.

A conference between the military authorities, represented by the Principal Medical Officer of the 2nd Military District, and the Australasian Trained Nurses' Association, represented by Dr. St. John Dansey (the President), Miss Watson (Matron of the Coast Hospital), Miss Blomfield and Miss Garrahan (Secretary of the Association), together with Miss Neal (Acting Principal Matron, Army Nursing Service), and Dr. R. H. Todd, representing the New South Wales Branch of the British Medical Association, was held on November 19, 1915, in Sydney.

The views put forward by the Australasian Trained Nurses' Association received the approval of the conference. The opinion was expressed that exception was taken to the regulations framed by the Victorian Trained Nurses' Association in regard to the utilization of nurses with mental training and limited general training. The proposals appeared to the Australasian Trained Nurses' Association to be unnecessary and undesirable for New South Wales, and possibly for other States, and the regulations would be cumbersome and difficult to work.

The departure of a large number of nurses for the front rendered it necessary to economize, within certain limitations, in the number of trained nurses employed in the hospitals. A suggestion had been made that the services of some of the orderlies should be dispensed with, and that their places should be filled by probationer nurses. Two questions were raised: (1) Is the supply of trained nurses sufficient for the needs of the military authorities? (2) What supplementary assistance should be given to these nurses, in order to free them from work that does not necessarily require their specialized training? In regard to the first question, it was pointed out that a considerable shortage of nurses existed. This shortage affected nurses in civil, and particularly country, hospitals, and in private practice.

The Acting Principal Matron stated that she had still on her list the names of 180 nurses who had volunteered for active service at home or abroad, and the number was being daily added to. She added that the number of trained nurses at present employed in Military Hospitals in New South Wales was 45.

The number of general trained nurses on the register of the Australian Trained Nurses' Association in New South Wales was 1,753. In order to gather as many capable nurses as possible, who might not be technically eligible for registration under the existing rules of the Association, the Council had passed a War Emergency clause, which would increase the number of registered nurses. A special examination had been held in September, at which 50 nurses passed. A further 58 had entered for the examination to be held early in December. If necessary, another special examination would be held in March.

The Council held the opinion that the number of nurses now registered and to be registered in the immediate future was sufficient to meet the needs of the military authorities, and that it would be inadvisable either that unregistered nurses should be employed or that the nursing profession should be swamped by granting permanent registration to a number of partially trained women.

With regard to the second question, it was stated that the needs of the military hospitals could be met by the employment of the Voluntary Aid Detachments as probationers and women orderlies. The members of these Detachments had received a certain amount of training in the duties they would be required to perform. They were already organized and anxious to work, and were prepared to work hard. They had offered their services merely for the special needs of war time. They would not be tempted after the war to presume in their experience in military hospitals, nor would they consider themselves trained nurses, and act as such to the public danger. It was held that ordinary

probationers would be much more inclined to do this, and to increase the number of semi-trained women who would compete with trained nurses.

The suggestion of passing on probationers from military hospitals to continue their training in civil hospitals had many disadvantages, and was not regarded with favour by the authorities of the hospitals.

It was pointed out that the employment of organized detachments of Voluntary Aids as auxiliaries to the trained nurses had been tried in English hospitals, and had been found to work well.

The War Emergency Clause (Rule XXI. b) was as follows: "Any nurse who has been engaged for a period of three years nursing in a hospital or hospitals recognized by, or deemed worthy of recognition by, the Council of the Australasian Trained Nurses' Association, and who can produce satisfactory evidence to that effect, together with certificates of competency from two reputable medical practitioners, and from a matron of a hospital in which she has trained, and who has passed the membership examination in Sydney for general nurses, shall be eligible for registration. Such nurses shall be entered in the register as 'Admitted under Rule XXI. b (War Emergency)'. This concession shall continue during the currency of the present war, or until such date as shall hereafter be fixed by the Council."

THE TREATMENT OF INSANITY IN PERSONS IN THE NAVAL OR MILITARY SERVICES.

The regulations in connexion with the Mental Treatment Act (Victoria), 1915, have been issued, and are published in the *Victoria Gazette*, dated November 3, 1915. The chief matters contained are as follows:—

A person having been on active service in the Army or Navy may be received into a recognized institution for the treatment of mental disorders on the production of a prescribed request and statement for a period not exceeding six months. The period may be extended by a certificate of the Inspector of the Insane for a further period. Details are given in regard to the proper entries to be kept in institutions for the treatment of naval or military patients suffering from mental disorders of admissions, deaths, discharges, escapes, recaptures, etc., of all patients received under the Act. The Inspector-General has the power to order the discharge or to approve of the discharge or to cause the transfer to another institution of any patient, and he may direct that any person under treatment under the provisions of the Mental Treatment Act, 1915, be committed to a Hospital for the Insane. The Inspector-General is empowered to visit and inspect every institution in which persons in the Naval and Military Service receive mental treatment under the Act. The Inspector-General, with the sanction of the Honourable the Chief Secretary, may withdraw the approval given to any institution to receive persons under the Act, and all persons under treatment in such institution shall be removed within fourteen days of the reception by the Superintendent of the notice of the withdrawal of approval.

Attached to the regulations are six schedules. These schedules prescribe the forms to be used in accordance with the regulations.

THE SCHLINK FUND.

During the past three weeks only two cheques have been received for the Schlink Fund. We venture again to call the attention of members to the fact that Dr. Schlink was driven by force of circumstances to defend his honour at a considerable cost, after an attack had been delivered on him in the Federal Parliament. The legal costs incurred amounted to close on £300. One-third of this amount has been subscribed by his colleagues. We ask for further subscriptions.

| | £ | s. | d. |
|--|------|----|----|
| Amount previously acknowledged | 99 | 3 | 0 |
| Dr. R. Spencer Godsall | 1 | 1 | 0 |
| „ Lennox G. Teece | 1 | 1 | 0 |
| Total | £101 | 5 | 0 |

Abstracts from Current Medical Literature.

MEDICINE.

(186) Long Quiescence of Leukæmia.

F. Parkes Weber (*Proc. Roy. Soc. of Med.*, May, 1915) records the case of a married woman, aged 63, who sought advice in March, 1909, for bearing down pains, which seemed to come on when she became fatigued from walking. Nothing abnormal was found on gynæcological examination, but the spleen was found to be greatly enlarged, extending downwards beyond the anterior superior iliac spine. The liver could not be felt. The inguinal glands were moderately enlarged on both sides, the axillary glands could only just be felt, and the cervical glands were apparently not enlarged at all. For two months the patient was treated in hospital with atoxyl injections and radium applications. The spleen decreased distinctly in size under treatment, and the lymphatic glands in the groins became scarcely markedly smaller. On December 6, 1909, the spleen did not quite reach the level of the anterior superior iliac spine. The differential blood count on March 4 showed: Hæmoglobin, 80%; red cells, 4,100,000; leucocytes, 57,000; lymphocytes, 94%; polymorphonuclears, 0.8%; large hyalines, 2.4%, and intermediates, 2.8%. No nucleated red cells were found. On December 6 the blood count showed:—Hæmoglobin, 82%; red cells, 5,740,000; leucocytes, 47,120; lymphocytes, 89.4%; polymorphonuclears, 10.0%; eosinophiles, 0.2%; basophiles, 0.4%. On December 4, 1911, the patient looked well, and only complained of rheumatic pains in the feet. The inguinal glands were moderately enlarged on both sides, and the spleen could be felt extending down to below the anterior superior iliac spine. Blood examination showed:—Hæmoglobin, 70%; red cells, 5,380,000; leucocytes, 95,600; lymphocytes, 96.6%; polymorphonuclears, 3.2%; eosinophiles, 0.2%. The red cells appeared normal, and no nucleated reds were seen. In March, 1914, the patient appeared much the same. Blood count showed:—Hæmoglobin, 77%; red cells, 5,160,000; leucocytes, 123,800. Lymphocytes were 96.5% of the leucocytes. The author states that one might think that the long quiescence of the leukæmia was due to the patient's age, just as certain diseases, such as diabetes mellitus, tend to assume a more benign form in elderly persons; but this can scarcely be admitted, for several cases of acute, rapidly fatal leukæmia have been recorded in elderly persons. The quiescence and long duration of the disease in the present and several other published cases furnish a ray of "prognostic hope" in leukæmia, but it must be admitted that recovery in an undoubted case of leukæmia, with or without treatment, has not yet been recorded.

(187) Syphilis and Salvarsan.

S. Steiner (*Medical Record*, April 24, 1915) holds that *spirochaeta pallida* and *refringens* are merely stages of the same organism. As regards the conflicting opinions as to whether the infection is hæmatogenous or along the route of the lymphatic circulation, he strongly supports the latter theory for the following reasons. (1) The invaders select the meagre defences of the lymphatics, where they have merely to pass through a thinly guarded wall of endothelium, in preference to the more strongly guarded walls of the capillaries. (2) A lymphangitis follows immediately the invasion of the spirochaetes, while the group of glands nearest to the site of infection becomes subsequently enlarged. (3) The lymphatic channels and glands, upon examination immediately after the appearance of the chancre, have been found full of spirochaetes, whereas the blood capillaries only occasionally show a few undeveloped forms of the micro-organism clogged up in a localized endarteritis. (4) The blood of the patient is not able to carry contagion in the pre-chancrous stage. As regards treatment, he insists on the removal of the chancre where possible. He does not assert that this will abort the disease, but it will rid the patient immediately of a focus, sending thousands of organisms into the lymph stream, and so make the administration of salvarsan more efficacious. Salvarsan is rapidly eliminated from the body, hence it must be administered frequently, and at intervals of from five to eight days. Otherwise, only the organisms existing in the circulation will be destroyed; the armies of those forming behind them will not be affected. Maximum doses should be used; repeated small doses have not enough power to kill a large number of organisms. Further, small doses make the organism arsenic fast, thus helping to defeat the purpose for which the drug was intended.

(188) Cheyne Stokes Breathing.

F. T. Fulton (*Heart*, vol. vi., No. 1, 1915) records some observations on the respiration and pulse of a patient with Cheyne-Stokes breathing. Two types of breathing have been described under this name. In one type, associated with increased intra-cranial tension, the period of apnoea is accompanied by a fall in blood pressure and a diminution in the pulse-rate, while the period of hyperpnoea is accompanied by an increased blood-pressure and a higher pulse rate. In the second type, which occurs in connexion with cardio-vascular lesions or renal disease there is a fall of blood-pressure and a slowing of the pulse in the period of dyspnoea, and an increased blood-pressure and a quick pulse in the period of apnoea. The history, recorded, is that of a man, aged 48, suffering from chronic Bright's disease. He had complained of shortness of breath on exertion for eighteen months previously. He had been in hospital for four months with ortho-

pnoea, general restlessness, and insomnia. He showed general anasarca. He had some hypertension. The dyspnoea was periodic. Tracings showed that the respiratory period was 30 seconds, 20 seconds of dyspnoea and 10 of apnoea. The pulse-rate in dyspnoea was about 45 beats per minute, and during apnoea 80 per minute.

(189) Auricular Fibrillation Following Heart-block in Diphtheria.

J. Parkinson describes the history of a man aged 22, admitted to hospital with pharyngeal diphtheria (*Heart*, vol. vi., No. 1, 1915). There was no previous history of rheumatic fever or of any other infection except measles. He had been ill two days. Cultures from the throat confirmed the diagnosis. Two doses of antitoxin, amounting to 10,000 units, were injected on the day of admission. The patient improved greatly in two days. The improvement continued until the twentieth day of the illness, when the glands of the neck became swollen, while the joints were painful, but not swollen. The temperature rose to 102° F. The pulse-rate increased to 124 beats per minute. On the twenty-third day of the illness it was noted that the pulse had fallen to 62 beats per minute. Seven days later tracings were taken, when complete heart-block was found, the auricles beating at 82 and the ventricles at 53 per minute. Three days later the polygraphic records showed the presence of auricular fibrillation. Six weeks later the patient was examined in the Cardiac Department of the London Hospital, and electro-cardiograms were taken to confirm the presence of auricular fibrillation. At intervals of three months the patient's heart has been examined, and the presence of auricular fibrillation noted. The rate is 110 times per minute. The patient can work hard without any shortness of breath.

NEUROLOGY.

(190) The Criminal Problem.

Edith R. Spaulding has subjected the experience gained at the Reformatory for Women in Framingham, Massachusetts, to a critical analysis, with a view to setting up a reliable classification and basis for segregation of criminals (*Boston Med. and Surg. Journ.*, October 7, 1915). She has supplemented this material by the statistical records of the penal institutions in the same State. The immediate study was based on the record of 500 female inmates of the Reformatory. These women were dealt with by a permanent segregation, partial segregation and parole. By permanent segregation is meant committal to an institution for defective delinquents or the feeble minded. The frequency of this form of treatment was equivalent to 24.8%. By partial segregation is meant a truly indeterminate sentence. The indeterminate sentence practised is, according to the author, not long enough in many cases to give the patient sub-

cient time to recover. By parole is meant strict oversight outside the institution on the understanding that the individual will be recommitted if the parole is violated. The primary analysis of the 500 women shows that 1.2% of the patients were imbeciles, 14.8% were morons, 29% were sub-normal, 20.4% were dull, 13.6% were "fair," and 21% were "good." Of the first class one patient was a psychopathic; of the second about one-fifth were neuropathic, and another fifth were epileptic, while one-twelfth were hysterical, and one-sixteenth psychopathic; of the third about one-third were neuropathics, one-sixth were epileptic, rather less were psychopathic, and approximately one-sixteenth were hysterical. Of the dull patients, 32% were neuropathic, 15% were epileptic, 11% were psychopathic, and 8% were hysterical. The patients tabulated under the rubric "fair" were psychopathic in 19%, epileptic in 19%, neuropathic in 14%, and hysterical in 11%. Those whose mentality was good showed a neuropathic tendency in 24%, an epileptic tendency in 13%, and hysterical tendency in 13%, and a psychopathic tendency in 11%. Of the 500 women, no nervous defect was found in 36.4%. The author continues to subject the figures to a critical analysis, and concludes that the adequate provision by the State for the permanent custodial care of all committable cases of mental defect is necessary. She pleads for the establishment of laboratories in the courts and in the correctional institutions for the study of the mental condition of the offenders. Facilities for classification and for the treatment of the various types are essential. In regard to treatment the provision of hydro-therapeutic apparatus is pleaded for. She urges the adoption of an indeterminate sentence, which would enable those responsible to treat the patients until they could be allowed to return to the community with safety.

(191) Senile Mental Impairment.

I. L. Nascher records the clinical histories of a series of cases of senile mental impairment of different types and different degrees of severity. (*Amer. Journ. of Clin. Med.*, June, 1915). An aged minister, who had formerly been bright and well-informed, was unable to concentrate his attention on matters of general interest. His conversation always reverted to theological matters, and brain fog, mental confusion, and drowsiness were evident after a short time. An old merchant was compelled to retire from business five years before on account of physical debilities. He became depressed mentally, hypochondriacal, melancholic, and finally demented. He would sit for hours looking at the wall, quite oblivious to his surroundings. A third patient, an old manufacturer, was highly intelligent, and took part in serious discussions. His mental deterioration took the form of becoming suspicious in business matters and intensely egotistical. His mental

impairment was apparent only to those who knew him, or who examined him from this point of view. A lawyer had formerly been very capable, exact and careful. His letters had become rambling, and the writing towards the end indecipherable. He was formerly reticent about himself, but had become egotistical. He believed that he was as capable as ever, that he would live to be 100 or 120 years of age, and that he was in perfect health. He associated with spiritualists, theosophists, and others of that kind. A medical man had become more serious, less aggressive, and less energetic, and his contributions to literature were not as elaborate or as frequent as in early days. The only evidence that these signs were associated with mental impairment was that the subject evinced a more rapid brain fog than formerly. The last male patient was a man of over 80 years of age, whose mentality had become slow, whose outlook limited, and whose facial expression was that of an idiot. The case is described as one of senile climacteric. There were two female patients. In the first there was signs of slow mental impairment coming on for 10 years. The patient's interests became restricted until she would speak of nothing but herself, her home, and her cat. Later she forgot the names of her children. The other patient was 83 years of age. She was fond of society, and especially of the young, resorted to youthful garments, cosmetics, etc., and weighed joking proposals of marriage seriously. The author adds details of a case of early senility in a man aged 60 years.

(192) Hypopituitarism.

F. Langmead (*Proc. Roy. Soc. Med.*, June, 1915) records a case of a male aged 19 years 3 months with symptoms of hypopituitarism. The patient had always been backward, and did not walk alone till nearly three years old. He did not talk properly till nearly four years of age. At school he made but little progress. Between the ages of five and seven years he was kept in bed on account of tubercular disease of left hip-joint. At that time he became very thin. Afterwards he attended a "cripple" school for two years. He then seemed healthy, but slow in learning. At the age of twelve he began to get very fat. He remained at school till the age of fourteen, and since then had done a little light work. He was very sensitive about his size, and shunned the society of other boys. Since Christmas, 1914, he had six convulsions, without any aura, and he bit his tongue in some of them. The longest fit lasted about ten minutes. Since the onset of fits he had complained of slight headache. From earliest infancy he had passed a large quantity of urine. In the family history there was nothing of note. At the time of report he was extremely obese. Height, 58 in.; upper arm, circumference, 11½ in.; forearm, right 11 in., left 10½ in.; chest, 31 in.; abdomen (at umbilicus), 43 in.; calf, 14 in. His mental and physical devel-

opment, were those of a boy of 11 or 12 years, rather than 19 years. The genitalia were rudimentary, and the testicles no larger than peas. There was no hair on the face, but some on the suprapubic region. The breasts and general development were rather of the female type. The voice did not seem to have broken, but was not strikingly infantile or feminine. Polydipsia and polyuria (104 to 300 oz. daily) were present, but glycosuria was absent. The optic discs and fields of vision are normal. The blood pressure measures 110 to 130 mm. Hg.; but it was difficult to estimate with accuracy, on account of the obesity. The pulse was small. The patient weighed 11 stone. The diagnosis was established by a skiagram of the pituitary fossa, which was seen to be minute, the posterior clinoid region being greatly thickened.

(193) Treatment of Syphilis of the Brain.

The proof that general paralysis of the insane is an active syphilitic disease has led to the introduction of intradural medication. G. O. Ireland and C. Stuart Wilson (*Journ. Amer. Med. Assoc.*, September 25, 1915) point out that the choice of technique in intradural treatment lies between the methods evolved by Swift and Ellis, Ravaut and Byrnes. They have adopted the last method in view of the high cost and scarcity of salvarsan, and particularly because this method is apparently free from danger, and is cheap. The technique is as follows:—About 40 c.cm. of blood are taken under aseptic conditions from a vein in the forearm. The serum is allowed to separate. To 12 c.cm. of serum 1 c.cm. of sterile solution of mercuric chloride containing 1/100 gr., and 17 c.cm. of sterile normal salt solution are added. The resultant fluid, measuring 30 c.cm., is heated to 56° C. for thirty minutes. Lumbar puncture is performed, and from 15 to 30 c.cm. of fluid are withdrawn. The 30 c.cm. of dilute mercurialized serum are injected slowly. In some cases they use neosalvarsan by the method described by Swift and Ellis. In all 23 patients suffering from general paralysis were treated in this way. In some cases autogenous serum was used, and in others the pooled serum of several persons. The autogenous serum was found to be preferable. In 75% some improvement followed the treatment. A tendency to relapse was noted in about 40% of the improved cases. The improvement was more marked from a clinical than from a seriological aspect.

(194) Amyotonia Congenita.

J. Collier records a case of a child in which the diagnosis of probable amyotonia congenita was made (*Proc. Roy. Soc. Med., Neuro. Section*, June, 1915). The patient had difficulty in assuming the upright position, was not able to run, and dragged his feet. The ankles were turned in. The musculature was small, but there was no local wasting. Hypotonus of the muscles of the leg was present. The response to faradism was low.

British Medical Association News.

SCIENTIFIC.

A clinical meeting of the Victorian Branch and of the Melbourne Paediatric Society was held at the Children's Hospital, Carlton, on November 10, 1915, Dr. A. V. M. Anderson in the chair.

The first case was shown by Dr. M. D. Silberberg. The patient was a child, aged 12 days. It was suffering from *Erb's paralysis*. The labour had been conducted in the External Department of the Women's Hospital. On enquiry, it was ascertained that the pregnancy had been a normal one, and that no instruments had been used at the delivery. The labour was easy, no chloroform was employed, and there had been no delay in the birth. No information was available in regard to the measurements of the mother's pelvis. The patient was the ninth child. A hæmatoma was palpable in the posterior triangle of the neck, and a fracture of the clavicle was apparent. There was complete loss of movement of all the muscles of the left upper arm. Dr. Silberberg described the case as an instance of Klumpke's type of obstetric paralysis of the arm. He sought advice in regard to the treatment. Splinting, massage, or operation could be resorted to.

Dr. Douglas Stephens recommended that the arm be put up in splints in a position of abduction for one month. In the absence of any indication of recovery of muscular power, he advised an operation.

Dr. J. Bullen demonstrated a patient for Dr. J. D. King Scott. The patient, a girl, aged five weeks, had a soft, tail-like projection behind the anus, well below the coccyx. It was probably either a *lipoma* or a *teratoma*. It was proposed that the growth should be removed in a few days.

Dr. H. Douglas Stephens showed a number of cases.

(1) *Spina bifida*.—He showed two cases illustrating different stages in the evolution of this malformation. The first patient was a female child, aged nine weeks. The Wassermann reaction was negative. At the time of birth a small tumour was noted in the sacro-lumbar region. The child's development was so poor that no operative treatment had been adopted. At first, an area of the size of a florin was discharging, but this area had become very much smaller after the application of spirit dressings. There was a characteristic patulous anus. In addition, marked *genu recurvatum* and typical *talipes equinus*, which are so often associated with cases of this kind, was seen. The meningeal myelocoele was increasing in size. He proposed to operate on it within a few days. The fontanelles were fairly full; the posterior one had developed only in the last ten days. The child was obviously developing hydrocephalus, in spite of the increase in size of the tumour. When the myelocoele was illuminated, the nerves could be seen spreading to the apex of the tumour.

The second patient was a male child, aged five months, with a receding sacral meningo-myelocoele and slight hydrocephalus. The Wassermann reaction was negative. The head circumference was stationary; the vertical measurement was increasing at the expense of the lateral. There were blue sclerotics. This sign was not associated with any softening of bone. The child could see, and was able from time to time to fix his attention. In this respect there was a distinct improvement. There had been a small tumour in the lumbo-sacral region, about one-third of the size of that of the first case. The tumour was discharging. It had shrivelled up under treatment with spirit dressings. The separation of the spinous processes could be felt in the neighbourhood of the tumour. The child had a *genu recurvatum*, but no *talipes equinus*. There was, however, *talipes calcaneus*, which was probably due to a spasm of the extensor muscles of the leg. He could move his legs well. The anus was not patulous, as in the former case. There was a characteristic growth of hair around the tumour. The hydrocephalus was a condition secondary to the *spina bifida*. Dr. Stephens had found that the chief dangers following operative treatment were meningitis and acute hydrocephalus.

(2) *Hare lip*.—Dr. Stephens showed three cases of this deformity. The first case was one of single, incomplete hare lip, without cleft palate, but with flattened nostril. In

the second case, there was a single hare lip on the right side, extending into the nostril. There was complete cleft palate. The patient was a fifth child. Three of the four remaining children had had hare lip and cleft palate, and the fourth had a rupture. The mother of the patient had had two miscarriages of three months' fetuses, both of which had had hare lip. The Wassermann reaction in the patient was negative. The result of the test applied to the mother's serum had not been received up to the time of reporting the case.

Dr. Jeffreys Wood instanced a family of six children in the Launceston General Hospital. All the children had had hare lip. Dr. Harvey Sutton pointed out that, according to the records of the Eugenics Laboratory, in London, 40% of the cases of hare lip were hereditary.

The third patient had been operated on a year before for hare lip. A further operation for cleft palate had just been completed, and the silver wire sutures had been removed that day. Dr. Stephens stated that he preferred to operate on hare lips as soon after birth as possible, and on cleft palate between the first and second year of life.

(3) *Congenital dislocation of the hip*.—Two cases of this condition were shown. The first was that of a boy, who had been demonstrated before a meeting ten months previously. He was five years of age, a cretin, with double congenital dislocation of the hip. At first there had been extreme lordosis. The patient had been treated with thyroid gland for some years. An X-ray photograph revealed a peg-top pelvis; the heads of both femora were situated outside the acetabula. Double reduction had since been performed. Dr. Stephens had advised against the operation, as the child was cretinoid, but the mother had insisted, and had accepted the risks. His intelligence had improved markedly. The plaster had been removed three weeks before, and the boy was able to walk. Both legs were slightly everted. The treatment consisted of massage and exercises. The second patient was a girl, aged six years, who had a right congenital dislocation of the hip. A skiagram showed that the head of the femur was outside the cotyloid cavity. The dislocation had been reduced two and a half months before. The head had slipped back into the socket "with a bang." Dr. Stephens regarded the age of six years as late for the performance of this operation. There was some danger of separating the epiphysis from the diaphysis, and of rupturing the femoral nerve.

(4) *Malignant peritoneal tumour*.—Dr. Stephens showed a girl, aged seven years, who had been brought to him with a history of icterus of 18 months' duration. The patient's parents were Russians, who had been in Assyria. It had been difficult to elicit information from them. Lumps were felt in the abdomen, and the case was thought to be tubercular or sarcomatous. The operation revealed a retro-peritoneal growth, not tubercular, but very extensive. The Wassermann reaction was negative, and von Pirquet's test, both with human and bovine bacilli, was also negative. In regard to treatment, he raised the question whether it would be advisable to inject "606," to place radium within the growth, to inject Coley's fluid, which reduces malignant at times, or to try X-rays.

(5) *Degeneration of bone after injury*.—Four and a half years before the patient, a girl, aged 11, had had an injury to her arm when in Scotland. The bone had subsequently become diseased. A doctor had removed a portion of the diaphysis of the humerus, and had inserted a piece of the patient's own tibia. She had recently had a fall and had broken her humerus. An X-ray photograph was shown to demonstrate the position of the fragments. Union had taken place. Another skiagram was exhibited, to demonstrate the marked decalcification of the lower part of the humerus. The arm was very weak, although it was fairly serviceable. Both epiphyses should have been present, as not more than four inches of the diaphysis had been removed.

Dr. Harvey Sutton showed a girl, aged 13½ years, with persistence of the temporary teeth, in addition to the normal development of the permanent teeth. She was five years behind her age, according to the Binnet scale. Her hands were coarse and her fingers short. Her sister, aged nine years, had normal teeth. Her mentality was much better. He also showed a boy, aged 11, in whom the hypo-

plastic type of teeth was present. The molar teeth had little pinnacles, with brown, crumbling patches. This is not met with in ordinary caries. The condition was due to an interference with the growth between the age of six and eight months. It was rarely found in Australian children; the frequency was less than 1 in 1,000. In immigrant children, like those from Glasgow, Leeds or London, these teeth were frequently found. They occurred in 10% of immigrant children. There were numerous yellow opacities scattered generally about the teeth. Pinnacles were found on the canines. The condition was probably due to an increased lime content of the water, and was, therefore, a disturbance of calcium metabolism.

Tumour of the cerebello-pontine angle.—Dr. Bullen showed a case of cerebellar tumour for Dr. F. Hobill Cole. The patient was a boy, aged eight years. He had been shown at a previous meeting about three months before, when the diagnosis of tumour of the cerebello-pontine angle had been made. When he was admitted there was a staggering gait, with a tendency to fall backwards and to the left. There was marked nystagmus and optic neuritis. There was no atrophy of the muscles of the hand, but some of those of the feet. Cerebellar decompression was performed a week later. The occipital bone was removed, and the dura incised. At first the mental condition had become worse, but subsequently the patient had improved considerably. After the operation, the patient had become blind, but his eyesight had become perfect since. He could not walk, and was very tremulous, especially on the left side. The optic neuritis cleared up. The patient had had a fall from a finker in February, 1915.

Dr. Bullen explained that after cerebellar decompression, the patients were invariably kept on the operating table, face downwards, for two hours. The head was not allowed to be raised. Those patients who had been moved under two hours had died immediately.

Dr. Leon Jona instanced animals that had been decerebrated living for days if left alone. They died immediately on being moved. A hæmorrhagic clot was found on the surface of the medulla post mortem.

Dr. N. J. Bullen showed a boy, aged 13 years, who had been shot in the neck on September 18, 1915, by the accidental discharge of a rifle. The bullet had entered the left side of the neck. The patient had lost the use of the left arm. There was slight movement of the right arm, and pain in the right wrist. On examination, it was found that the biceps, triceps, and supinator tendon reflexes were increased on both sides. Babinski's sign was marked on both sides. There was complete loss of sensation on the right side to the level of the first dorsal vertebra. On the left side the sensation of heat and pain were present, but diminished. He retained some control over defæcation, and was conscious of the act of micturition. The sensory impulses were normal down to the sixth cervical nerve. The seventh cervical nerve showed some depression, but there was a discrimination between the sensation of heat and cold. The patient lay quietly, and answered all questions well. A skiagram revealed that the bullet was lodged in the spinal cord, on the left side, at the level of the sixth or seventh cervical segment. Dr. Bullen was unable to explain the paralysis in the left leg. On the right side the sensation was dull in the area corresponding to the sixth cervical to the second lumbar roots. Below this level it was completely absent.

Dr. Anderson suggested that the bullet must have injured some nerve fibres on its passage downward.

Dr. N. J. Bullen showed two patients who had recovered from cerebro-spinal meningitis. The bacteriological examination of the throats of both was negative. The first patient was a girl, aged 3½ years, who had been admitted into hospital two and a half months before. She had had irido-cyclitis and marked keratitis. There was a dislocation of the lens of the left eye. The child was in good health, and was running about the hospital. The second patient, aged five years, had been admitted in a state of collapse. There was a dislocation of the lens, which could be seen lying at the bottom of the posterior chamber.

MEDICO-POLITICAL.

The following have been elected members of the New South Wales Branch:—

- Dr. Victor Marcus Coppleston, Callan Park Hospital.
Dr. Edward Hamilton Loxton, "Netherley," Wahroonga.
Dr. Cedric Walter Wilberforce Murray, Wentworth Street, Parramatta.
Dr. M. J. Slattery, c/o Dr. Howse, College Street, Sydney.
Dr. Charles Wynwood Bray, Rabaul, New Guinea.
Dr. Cedric Murray Samson, Hinton Hall, Margaret Street, Sydney.
Dr. Clive Frederick Robinson, St. Andrew's College, Sydney.

BELGIAN DOCTORS' RELIEF FUND.

Queensland.

We have been requested by the Honorary Treasurer of the Queensland Branch to publish the sixth list of contributions of the Branch to the Belgian Doctors' Relief Fund.

| | £ | s. | d. |
|--|-----|----|----|
| Amount previously acknowledged | 81 | 10 | 6 |
| Dr. Bourne, E. E., Brisbane (October and November contributions) | 1 | 0 | 0 |
| „ Cooper, Lilian, Brisbane (November contribution) | 2 | 0 | 0 |
| „ Robertson, W. N., Brisbane (September, October, and November contributions) | 12 | 0 | 0 |
| „ Roe, A. S., Brisbane (November contribution) | 1 | 1 | 0 |
| „ Turner, A. J., Brisbane (November contribution) | 2 | 2 | 0 |
| Total | £99 | 13 | 6 |

Public Health.

THE HEALTH OF VICTORIA.

The following notifications have been received by the Department of Public Health, Victoria, during the week ending November 18, 1915:—

| | Metro-politan. | | Rest of State. | | Totals. | |
|---------------------------------|----------------|-------|----------------|-------|---------|-------|
| | Cs. | Dths. | Cs. | Dths. | Cs. | Dths. |
| Diphtheria | 40 | 2 | 21 | 0 | 61 | 2 |
| Scarlatina | 8 | 0 | 7 | 0 | 15 | 0 |
| Enteric Fever | 5 | 0 | 3 | 1 | 8 | 1 |
| Pulmonary Tuberculosis | 29 | 13 | 12 | 4 | 41 | 17 |

The following is the return of cases of epidemic cerebro-spinal meningitis notified to the Board during the week ending November 18, 1915:—

| | Metropolitan Area. | | Rural Districts. | | Totals. | |
|-------------------|--------------------|--|------------------|--|---------|--|
| | Cases. | | Cases. | | Cases. | |
| Military | — | | — | | 3 | |
| Civil | 14 | | 2 | | 16 | |

SMALL-POX IN NEW SOUTH WALES.

The following cases of small-pox have been notified to the Department of Public Health, New South Wales, during the week ending November 21, 1915:—

| | Cases. |
|---|--------|
| Newcastle and surrounding district | 23 |
| Sydney (infected at Newcastle) | 1 |
| Total | 24 |

INFECTIVE DISEASES IN QUEENSLAND.

The following notifications have been received by the Department of Public Health, Queensland, during the week ending October 30, 1915:—

| Disease. | No. of Cases. |
|------------------------------------|---------------|
| Enteric Fever | 25 |
| Pulmonary Tuberculosis | 9 |
| Cerebro-Spinal Meningitis | 6 |
| Diphtheria | 23 |
| Varicella | 12 |
| Erysipelas | 2 |
| Ankylostomiasis | 1 |
| Scarlet Fever | 1 |
| Malaria | 3 |
| Total | 82 |

The following notifications have been received by the Department of Public Health, Queensland, during the week ending November 13, 1915:—

| Disease. | No. of Cases Reported. |
|-----------------------------------|------------------------|
| Enteric Fever | 27 |
| Pulmonary Tuberculosis | 13 |
| Diphtheria | 21 |
| Varicella | 26 |
| Cerebro-Spinal Meningitis | 4 |
| Erysipelas | 1 |
| Scarlet Fever | 5 |
| Total | 97 |

INFECTIVE DISEASES IN WESTERN AUSTRALIA.

The following notifications have been received by the Department of Public Health, Western Australia, during the week ending November 6, 1915:—

| District. | Diph- theria. Cases. | Enteric Fever. Cases. | Pulmonary Tuber- culosis. Cases. | Ery- sipelas. Cases. | Beri. Beri. Cases. | Cerebro- Spinal Meningitis. Cases. | Oph- thal- mia. Cases. |
|-----------------|----------------------------|-----------------------------|---|----------------------------|--------------------------|---|---------------------------------|
| Fremantle .. | 1 | — | 1 | — | — | — | — |
| Fremantle E. | — | — | 1 | — | — | — | — |
| Subiaco .. | 1 | — | — | — | — | — | — |
| Perth .. | 3 | 3 | 5 | — | — | — | 1 |
| Maylands .. | — | — | 1 | — | — | — | — |
| Midland Jun. | — | — | 1 | — | — | — | — |
| Kalgoorlie .. | 4 | — | — | — | — | — | — |
| Boulder .. | 1 | — | 1 | — | — | — | — |
| Kalg. Rd Dis | 1 | — | — | — | — | — | — |
| Kojup .. | 1 | — | — | — | — | — | — |
| Wickepin .. | — | — | — | 1 | — | — | — |
| York .. | 1 | — | — | — | — | — | — |
| Jennac'bbine | 2 | — | — | — | — | — | — |
| Troopship .. | — | — | — | — | — | 1 | — |
| Broome .. | — | — | — | — | 1 | — | — |
| Totals.. | 15 | 3 | 10 | 1 | 1 | 1 | 1 |

CEREBRO-SPINAL MENINGITIS.

We have been informed by the Acting Commissioner for Public Health that up to the end of the first week of November there have been three cases of epidemic cerebro-spinal meningitis in the State of Western Australia. One of the patients died. A certain number of meningococcus carriers have been detected, and are being dealt with by isolation.

INFECTIVE DISEASES.

The official report issued by the Federal Quarantine Bureau on November 10, 1915, contains information in regard to the incidence and mortality of plague, cholera and variola. From August 29 to September 25, 1915, there were 10,610 cases of plague in India, and 7,320 deaths. In Java, between the dates of August 27 and October 7, there were 445 cases, and 441 deaths. Twenty-eight cases were reported in Ceylon from September 5 to October 9, 1915. There were 4 cases and 3 deaths in Egypt between September 10 and October 7, 2 cases and 2 deaths in the Straits Settlements between July 30 and November 1, 1915, and 2 cases at Arzila, in Morocco, on September 3. The last case reported in the Philippine Islands was notified on September 12, 1914.

The only records of cholera given affect the Dutch East Indies. There were 121 additional cases, and 99 deaths. In the same country there were 191 cases of small-pox, and 42 deaths. One case of small-pox occurred in the Straits Settlements on September 20, 1915.

HEALTH OF THE METROPOLIS OF SYDNEY.

The mortality return for October, 1915, as supplied by the Government Statistician, shows that 610 deaths occurred in the Metropolis of Sydney, including 29 deaths of individuals previously resident outside the metropolis, and deaths classified as taking place in the islands and shipping in the harbour.

Thus, calculating on an estimated population of 752,500, the annual death-rate for the month works out at 9.72 per

1,000 of the population. Deducting the deaths of persons non-residents of the metropolis, in the mental hospitals of Leichhardt and Hunter's Hill (Callan Park and Gladesville), and adding to the deaths of previous residents of the metropolis occurring at the benevolent asylums, mental hospitals and consumptive sanatoria situated outside the metropolis, the number of deaths was 600, giving a corrected death-rate of 9.56 per 1,000.

Among children under one year of age, 111 deaths were recorded for the metropolis. There were 1,571 births during the month, giving a rate of 25.05 per 1,000 of the population, which is not satisfactory, being 15% below the average for October of the previous five years. The infantile mortality rate was 72 per 1,000 births, which is high, being 22% above the average for the month of the previous five years.

Infectious diseases were responsible for 50 deaths, of which 23 were due to measles, 6 to scarlet fever, 2 to influenza, 1 to whooping cough, 4 to diphtheria, 5 to typhoid fever, 4 to cerebro-spinal fever, 1 to erysipelas, and 4 to puerperal fever. Diarrhoeal diseases were credited with 49 deaths. Cerebral hæmorrhage caused 15 deaths, phthisis 40, cancer 56, diseases of the heart and blood vessels 73, pneumonia 43, and Bright's disease 30. Compared with the average in October for the previous five years, there were increases in the number of deaths from epidemic diseases and diarrhoeal diseases, with decreases in phthisis, cerebral hæmorrhage, diseases of the heart and blood vessels, senility and Bright's disease.

Three hundred and thirty-two cases of scarlet fever, 163 of diphtheria, 44 of typhoid fever, 2 of malaria, 3 of infantile paralysis or anterior polio-myelitis, and 110 cases of pulmonary tuberculosis were notified during the month.

Seventeen cases of phthisis (consumption of the lungs and consumption of the throat) were notified under the City Council's By-laws, and 17 premises were disinfected by the Council's trained staff, after the removal or death of the patients.

(Signed) F. M. SUCKLING,
Acting Medical Officer of Health.

THE HEALTH OF SYDNEY AND NEWCASTLE.

The usual monthly report on the vital statistics of the metropolis of Sydney and of the Newcastle district for the month of October, 1915, is published in the New South Wales Government Gazette of November 10, 1915.

During the month there were 1,571 births, which is equivalent to an annual birth-rate of 25.05 per 1,000 of population. This rate is 15% below the average for the previous five years. It is the lowest recorded during the past 12 months. There were 119 illegitimate births, which is equal to an annual illegitimate birth-rate of 1.89, as compared with 2.48, which was the equivalent annual rate for the preceding five months of October. While the decrease is very marked as compared with previous years, it was lower in November and December, 1914, and in January, February, and March, 1915. The number of births which took place in hospitals and public institutions was 259, or 16% of the whole.

The number of deaths was also lower than the average for October in the past five years, 610 deaths having been registered. The equivalent death-rate worked out at 9.72, as compared with 10.77 per 1,000 of population. The number of infants under one year of age included in the deaths was 114. This number is five more than the average for October in the previous five years. The infantile mortality was 72 per 1,000 births, as compared with 59. This rate has been exceeded only once during the past 12 months, viz., in December, 1914, when it was 87. In October, 1914, it was as low as 43. Two persons over 90 years of age died during the month, and 165 of 65 or over. More than two-fifths of the deaths took place in hospitals and public institutions.

From the table dealing with the causes of death, it appears that diseases of the cardio-vascular system accounted for 89 deaths. Of these, 54 were due to organic diseases of the heart, 15 to cerebral hæmorrhage, 7 to acute endocarditis, 5 to diseases of the arteries, 3 to embolism, 2 to aneurysm, 1 to angina pectoris, 1 to pericarditis, and 1 to other conditions of the circulatory system. Of the infec-

tive diseases, tuberculosis was responsible for 30 deaths, 19 of which were instances of pulmonary disease. Twenty-four deaths were caused by measles. There were 50 deaths from diarrhoea and enteritis, 29 from lobar pneumonia, 17 from lobular pneumonia, 8 from chronic bronchitis, 5 from scarlatina, 5 from enteric fever, 5 from cerebro-spinal meningitis, 4 from simple meningitis, 4 from diphtheria, 3 from syphilis, 2 from influenza, 2 from dysentery, 1 from pertussis, and 1 from erysipelas. The returns of the Board of Health in regard to the notification of infective diseases reveal that 44 cases of enteric fever, 332 cases of scarlatina, 163 of diphtheria, 3 of anterior poliomyelitis, and 2 of malaria occurred during the month.

Cancer proved fatal 60 times. In 18 cases the tumour was situated in the stomach or liver, in 12 in the peritoneum or intestine, in 10 in the female genital organs, in 4 in the mouth, and in 2 in the breast. Bright's disease was responsible for 29 deaths, and diabetes for 10. Of the causes of death during the puerperium, septicaemia is entered 4 times, hæmorrhage twice, and albuminuria with convulsions once.

In the Newcastle district, 180 births were registered in October. This is equivalent to an annual birth-rate of 36.84 per 1,000 of population. The same birth-rate was recorded in October of 1914, whereas the rate was lower in the month of October of each year from 1907 onwards. Of the 180 infants born, 11 were illegitimate, representing 6.11% of the total number of births. The illegitimate birth-rate has varied very considerably in the district during the past 10 years. There were 77 deaths, of which 24 took place in hospitals and public institutions. The death-rate was equivalent to an annual death-rate of 15.72. Of the 77 deaths, 35 affected infants under 5 years of age, and 20 under 1 year of age. The infantile mortality works out at 111 per 1,000 births. In October, 1907, it was 126, and in October, 1910, it was 129. With these two exceptions, the infantile death-rate for October was lower each year since 1906.

The number of deaths due to diarrhoea and enteritis was 11. This number is considerably higher than the average for October during the preceding 10 years. There were 9 deaths from pneumonia, which is the largest number recorded in October since 1906. Tuberculosis was fatal on four occasions, in one of which the lungs were the site of disease. Measles and diphtheria killed two patients each, all four being under five years of age. There were 17 cases of diphtheria notified during the month, 14 of scarlatina and 2 from enteric fever. One death was ascribed to an illegal operation.

THE DEAF, DUMB AND BLIND IN TASMANIA.

The Tasmanian Society for the Blind and the Deaf and Dumb has issued its 18th Annual Report for the year ending January 31, 1915. The report is divided into three sections, the commercial, the household and the educational. The revenue account showed an increase of £101 on the year's working, but the trading account of the factory and dépôt showed a loss of £318. The industrial department employed 20 workers, 15 of whom were blind, and three deaf. The total value of the work done during the year is estimated at £1,840. Brushes, chairs, mats, baskets, and halters were the articles made.

Bequests to the value of £25 and £50 and a legacy of £500 have been received during the year, and the subscriptions collected amounted to £811. The Superintendent of the Queensland Institution, after paying a visit to Hobart, expressed his opinion that the Tasmanian Society's Institution was creditably kept, the children's quarter neat and clean and the children bright and happy. The work in the shop seemed to him to be exceedingly well done, and a credit to the foreman.

Household.

The health of the pupils has been good, and the general arrangements and conduct of the Institution have contributed to the value of the work undertaken.

Education.

The number of children in the Deaf and Dumb School was 41, 24 being boys and 17 girls. There were nine chil-

dren in the Blind School, five of whom were girls and four were boys. During the past eleven years the number of pupils has increased from 5 to 50. Extensive alterations and additions to the Moore Street building were commenced in January, 1914, and will probably be completed before the end of the year 1915. It is anticipated that at least 20 fresh students will be admitted when the buildings are completed. The annual presentation of prizes took place in December. The children very unselfishly offered to forego their prizes if the money to be spent could be devoted to the Belgian Fund. The Committee appreciated the scholars' action, but determined that the funds could not be diverted in this way. The children thereupon asked permission to hold a fair for the same purpose. This request was acceded to, and, as a result, £26 was raised and handed to the Belgian Fund Committee.

The general education of the students proceeded satisfactorily. In addition, swimming, carpentry and dress-making were taught. In the Blind School, music and type-writing lessons were given to those pupils who showed aptitude.

Medical Matters in Parliament.

THE COMMONWEALTH OF AUSTRALIA.

In the Senate on October 28, 1915, Senator Russell moved "That leave be given to introduce a Bill for an Act to amend the Quarantine Act, 1908-12." The motion was carried.

A motion, by Senator Pearce, "That so much of the Standing and Sessional Orders be suspended as would prevent the Bill being passed through all its stages without delay," was agreed to by the Senate.

The Bill was presented by Senator Russell and read a first time.

The Bill read as follows:—

Be it enacted by the King's Most Excellent Majesty, the Senate, and the House of Representatives of the Commonwealth of Australia, as follows:—

1. (1) This Act may be cited as the "Quarantine Act, 1915."

(2) The Quarantine Act 1908-1912 is the Act referred to as the Principal Act.

(3) The Principal Act, as amended by this Act, may be cited as the Quarantine Act, 1908-1915.

2. Section four of the Principal Act is amended by inserting therein, after the word "protection," the word "treatment."

3. Section thirteen of the Principal Act is amended by inserting in paragraph (i) of sub-section (1) thereof, after the words "declare that any," the word "vessel."

4. Section twenty-eight of the Principal Act is amended by inserting in sub-section (1) thereof, after the word "voyage," the words "touching the sanitary condition of the vessel during the voyage."

5. Section thirty-five A of the Principal Act is amended—

(a) by inserting, in sub-section (1) thereof, after the words "of the vessel," the words "and all such other measures of quarantine";

(b) by inserting in that sub-section, after the words "from the disease," the words "or who have been exposed to infection from the disease may be ordered into quarantine and"; and

(c) by adding at the end of the section the following sub-sections:—

"(3) No person suffering from or suspected to be suffering from a communicable (infectious) disease shall quit the vessel on which he arrives in Australia without the written permission of a quarantine officer. Penalty: Five hundred pounds.

"(4) No person who is in charge of any person suffering from or suspected to be suffering from any communicable (infectious) dis-

ease shall permit the person to quit the vessel upon which he arrives in Australia without the written permission of a quarantine officer. Penalty: Five hundred pounds."

6. Section forty-five of the Principal Act is amended—

- (a) by omitting, in sub-section (1) thereof the words "be detained on board the vessel or in a quarantine station," and inserting in their stead the following words:—

"(a) be detained on board the vessel,

(b) be detained upon the premises upon which they are found, or

(c) be removed to and detained in a quarantine station," and

- (b) by omitting from sub-section (3) thereof the words "permit the person to leave the ship or quarantine station" and inserting in their stead the words "release the person."

7. Section seventy-three of the Principal Act is amended by adding thereto the following sub-sections:—

- "(2) A quarantine officer may ask any person subject to quarantine any questions concerning his personal health or liability to infection, and the person shall, to the best of his knowledge, information, and belief, truly answer the questions asked him by the quarantine officer. Penalty: One hundred pounds.

- "(3) A quarantine officer may, if he thinks fit, require a person, who has been asked questions in pursuance of this section, to verify, by statutory declaration, the answers given to the questions, and any person who refuses to comply with any such requirement shall be guilty of an offence. Penalty: One hundred pounds."

8. Section seventy-eight A of the Principal Act is amended—

- (a) by omitting the words "to be taken to any prescribed place and";

- (b) by omitting the words "to be taken to that place and"; and

- (c) by adding at the end of the section, the following sub-sections:—

"(2) A quarantine officer may, subject to the regulations, order any such vessel to be taken to an appointed place for the purpose of cleansing, fumigation, disinfection or treatment, and the master of the vessel shall cause her to be taken to that place. Penalty: One hundred pounds.

"(3) The Minister may order any vessel in any port in Australia to be taken to any other port in Australia for the purpose of cleansing, fumigation, disinfection or treatment and the master of the vessel shall cause her to be taken to that port accordingly. Penalty: One hundred pounds."

9. Section eighty-seven of the Principal Act is amended—

- (a) by adding at the end of paragraph (c) the words "and for prescribing measures of quarantine within any quarantine area";

- (b) by adding at the end of paragraph (c) the words "or within any specified part of Australia, or within any quarantine area";

- (c) by omitting paragraphs (f), (g) and (h) and inserting in their stead the following paragraphs:

"(f) for prescribing the precautions to be taken to prevent the ingress to or egress from a vessel, of rats, mice, mosquitoes or other vermin or species or kinds of animals or insects liable to convey disease;

"(g) for prescribing the measures to be taken by the masters or owners of vessels to destroy rats, mice, mosquitoes or other vermin or species or kinds of animals or insects liable to convey disease, which may exist on the vessels;

"(h) for prescribing and for establishing and maintaining on vessels or within any quarantine area of conditions unfavourable to, and to the migration of, rats, mice, mosquitoes or other vermin or species or kinds of animals or insects liable to convey disease, for fixing the time limit for the completion of any work necessary for the purpose of establishing such conditions, and for empowering the Minister, in case of default by the owner or master, to carry out any such work at the expense of the owner or master";

- (d) by inserting in paragraph (i), after the words "from proclaimed places," the words "and on voyages between Australian ports";

- (e) by inserting in paragraph (i), after the word "Australia" the words ", or spread";

- (f) by omitting paragraph (j);

- (g) by omitting from paragraph (u) the word "and"; and

- (h) by adding at the end thereof the following paragraphs:—

"(p) for prescribing the movements of any person subject to quarantine;

"(q) for prescribing measures of disinfection, fumigation, and other measures of quarantine which persons or goods subject to quarantine shall carry out or be subjected to; and

"(r) for prescribing the conditions under which any prophylactic or curative vaccine or serum may be prepared and offered for sale; and

"(s) for prescribing penalties not exceeding One hundred pounds for breaches of the regulations."

Senator Russell immediately moved:—

"That this Bill be now read a second time."

He said that the Bill involved no new principle. Everyone had an interest in preventing the entry into Australia of undesirable diseases which would cause serious trouble and expense if allowed to gain a footing within its borders. They had a fairly complete Quarantine Act, but no amendment had been made for three years.

Senator Keating interjected that this was a record as things went at this time.

Senator Russell said that the time was too long as far as quarantine was concerned. Many weaknesses had been discovered in the existing Act. The powers of the Department in relation to the masters of ships, in reference to cleansing a vessel and in relation to passengers were not clear. Again, when a dispute arose between a State Board of Health and the Commonwealth it was possible for disease to spread between the States while the matter was being settled by the respective Cabinets. It was therefore thought desirable to give the Commonwealth full power to settle the dispute after it had dealt with the disease. The main object of the Bill was to deal with the results of opening the Panama Canal. It was anticipated that, in consequence of this new route, yellow fever might be introduced into Australia. The mosquito, which was the only carrier of yellow fever, was found on the coast of Queensland and as far south as Newcastle. So far, this mosquito had not been infected with yellow fever. The purpose of the Bill was to tighten the provisions of the existing Act and to strengthen the hands of the Quarantine Department.

Senator Keating said that the Bill had just been circulated so that he doubted whether any honourable senator had had an opportunity to read it. He had been able to look only at the marginal notes and to glance casually at some of the clauses. Although the Assistant Minister had said that there was no new principle involved in the Bill, yet he thought that the powers of a quarantine officer were extended by clause seven. The officer was given, under this clause, power to ask any person questions as to his personal health or liability to infection, and the quarantine officer might require his questions to be answered by a statutory declaration.

Senator Stewart protested against the manner in which the Bill had been introduced. He said that the Government had arrived at the conclusion that they should introduce the Bill, vouchsafe very little explanation, afford no time to gain information as to the effects of the Bill, and pass it without delay. If this was the way business was to be carried out, the Government could be performed by ten or eleven Ministers, without the 111 other members. As he had no means of ascertaining the effects of the Bill, he would enter his protest against this mode of passing legislation.

Senator Frericks hoped that this amendment would have the effect of stiffening the Quarantine Act. He felt sure that the Government had the interests of the people of Australia at heart, and would not neglect to enforce strictly its provisions. He supported the increased powers given to the Federal authorities to enable them to enforce their views when differences occurred with the State Boards of Health. When small-pox was rife in New South Wales, the State and Federal authorities had done their duty, despite the complaints of the commercial section of the community of Sydney. Now, when they had a serious epidemic of meningitis in Victoria, with 150 deaths among 462 cases, nothing was done to enforce quarantine regulations by the Victorian Board of Health, simply because this very serious outbreak occurred just before that annual festival, the Melbourne Cup. If restrictions had been placed on the people, as they should have been, there would not have been the same influx of persons into Melbourne.

Senator De Largie commended the Government for the prompt manner in which they had brought forward this legislation. He was of opinion that the Government would have been guilty of laxity if they had resorted to the slow and deliberate methods of bringing in legislation. The general health of the community was the most important subject for which they had to legislate. The subject was difficult, as they had to grope in the dark, lay down their own precedents and find out their methods for dealing with diseases. It was of little use to look to other countries for guidance. The laws of the United Kingdom in this respect were not suitable. This was more a geographical than a racial matter. Scarlet fever was a disease for which quarantine was not enforced in Great Britain, but in India it was regarded as of more importance than small-pox. He trusted that the good work begun in Samarai by Dr. Jones would be extended to the mainland, and that the mosquito would be exterminated in this country.

Senator Turley said that if Senator Stewart desired more time to understand the Bill he could have moved the adjournment of the debate. If he had done so, the Government would have consented to the adjournment. He thought that they should go on with the Bill. The Constitution gave the Government power over all quarantine matters. The Commonwealth could legislate and administer legislation as far as quarantine was concerned in any way that might be deemed advisable. It had been thought that the best way to do this was to seek the assistance of the State Health Authorities, so as to avoid friction and to provide for the more efficient administration of the quarantine. He referred to the excellent work done by the Institute of Tropical Diseases at Townsville. The work of that Institute had provided the information as to the distribution of the mosquito that might serve as the agent for carrying the infection of yellow fever. He trusted that the Health Authorities would be given power to deal effectively with any vessel arriving at Australian ports from fever-ridden districts and, in that way, protect the community from yellow fever and other diseases.

Senator Russell replied to the objections of Senator Stewart.

The question was then resolved in the affirmative and the Bill read a second time.

The Senate then sat in Committee.

Clauses 1 to 6 were agreed to.

Clause 7, to amend section 73 of the Principal Act, by adding thereto sub-sections providing that a quarantine officer might ask any person subject to quarantine questions concerning his personal health or liability to infection, and might require persons who have been asked questions to verify the answers by statutory declaration, was debated at some length. The section in the Principal Act provided

that the master or medical officer of any vessel could be questioned by the quarantine officer.

Senator Stewart thought that, while an ordinary individual had some idea of his personal health, he could not be expected to answer questions on his liability to infection. He thought that the average man could only say that he did not know whether he was liable to infection or not. One man might be liable to infection but another not.

Senator Keating pointed out that the quarantine officer would determine the liability to infection. The persons questioned would give information as to their movements, contacts and relations with other persons in the previous period.

Senator Frericks sought information as to whether it would not be possible under this clause to take steps to combat the serious outbreak of meningitis in Victoria. So far, one person out of every three afflicted had died. As the disease had spread to all the other States except Western Australia, he asked the Minister for Defence to consult with his colleagues to take steps to have the matter dealt with by the National Government.

Senator Pearce said that he would like to make a statement about meningitis. The steps taken by the authorities in the military camps had stamped out the disease in New South Wales, Tasmania and South Australia. In reference to the remarks about the Victorian Board of Health, he would like to say that everything possible had been done by the Victorian Board of Health, in co-operation with the officials of the Defence Department.

Clause 7 was agreed to.

(To be continued.)

Correspondence.

WHITE AUSTRALIA POLICY.

Sir,—M.B. (Melb.) is opposed to the White Australia Policy on the grounds that white people cannot live and thrive in the northern part of Australia, solely because Nature has not endowed their skins with sufficient pigment, supposedly to protect them from the violence of the sun's rays.

He asks me, "Will not Dr. Pern admit that living organisms everywhere, including men, are pigmented to meet the demands of their light environments, or else they must be otherwise protected or suffer?"

If M.B. (Melb.) can produce undeniable evidence in favour of this assertion, his case is proved, and it would be absurd and even cruel to ask white people to go to the north of Australia to die slowly from the effects of the sun's rays.

The arguments against this theory brought forward by Dr. Jas. F. Merrillees have, however, far greater weight in my mind than the assertions made by M.B. (Melb.).

My particular aim has been to bring interest to focus on the settler, the man with the axe and the plough, the real maker of empire and nation, without whom there can be no industries, no great cities, no national security in Australia.

I have endeavoured to point out in my letters in this journal, in a letter entitled "Land Problems" in the Melbourne *Argus* of January 23, 1915, and again in the Melbourne *Age* of October 2, 1915, that Australia's failure to populate her north is due—not to the climate—but to disregard of the interests of the settler and to our Governments absolutely refusing to copy the lessons taught in opening up new lands by Canada, the United States and the great South American republics.

Hundreds of thousands of successful and prosperous farmers of to-day in the United States and Canada originally took up free freehold farms, without a cent to bless themselves with, under the care of the great railways and a sympathetic government, who had the sense to recognize that land was of no value to a State unless it was productive.

These men—"our poor relations" M.B. (Melb.) calls them (what would he call the hordes of Asiatics he wishes to inundate us and our civilization with, "rich relations"?)—are the pride of those countries, the basis of their power and industries.

Most of the great men of the world have been "poor relations."

Our only hope—the only hope of Anglo-Saxon civilization—lies in giving to "our poor relations" the land we

cannot develop ourselves, instead of continuing with our time-honoured, dog-in-the-manger policy, which is actually driving men off the land.

It is not reasonable to expect men on established farms and others well blessed with this world's goods to leave their homes and interests to go and open up new lands.

Is even the Australian-born settler given encouragement in this his native country?

The land he takes up is largely forest country, for which he pays from about ten to fifty shillings an acre. He is not given his land free and freehold, except in Western Australia, but can make it freehold if he can pay off the purchase cost within thirty years, meantime holding it on leasehold tenure so long as he meets the Government's charges.

Certainly, the Northern Territory is offering free farms, but not on freehold tenure, only on leasehold, which is not sufficient attraction to bring men to a new country.

He is invariably in solitude, a long way from a railway, is served by most indifferent roads, and wild dogs, rabbits, foxes, fires and dry spells and other pests have to be reckoned with, and the farther he is from the capital city of the State the more he is charged for freightage on supplies brought to him and on produce he sends away.

It more often than not takes one even two generations of hard labour to convert his patch of wilderness into a made farm.

If he cannot meet his liabilities at any time, off he goes.

And off they go by the thousands, through no fault of their own. And wise people in the cities then say the settler is lazy, won't work, the lure of the city, not enough pigment in his skin, etc., etc.; anything, in fact, but the obvious and patent reason.

Now and again a little commission sits, and describes how poor forest settlers have been put on to closer settlements farms, and charged about double or treble for the land than what it was worth.

Quite a mistake, of course. Nobody's fault. This is an everyday occurrence, and excites no interest that a few more families have been ruined and driven to the city.

Everybody in Australia has everything to gain by settling Australia with white people, and stands everything to lose by refusing to do so.

M.B. (Melb.) in criticizing my letter further states that "It is proposed that 'our poor relations' should be distributed over the Territory on 200 acre blocks."

I am here accused of advocating the very thing I take such pains to explain should be avoided, viz., the present haphazard methods of the Governments of dumping a few settlers here, and a few there, instead of compact system. What I did say is this:—

"I would like to suggest a scheme which seems to offer great scope for rapid and successful land settlement, and which might form the nucleus of a great industry, and which might soon become one of the leading national industries of Australia, viz., cotton growing. In settling any new country, some of the main difficulties to be overcome are: (1) The difficulty of a man unaccustomed to a farming life suddenly having to learn some branch of farming, with prospects of more or less immediate success. (2) Solitude. (3) An immediate and stable market to dispose of produce. (4) Erecting of homestead, fencing, etc. (5) Education of children. (6) Railway and road facilities. It is not reasonable to expect any man with a family quite unaccustomed to Australian bush life to make a success of general farming or grazing, dumped down in the bush to struggle for himself, however willing the man may be.

"The settler of to-day is not of the old pioneer type; he is brought up under modern conditions of comfort and easy surroundings, and cannot long tolerate the solitude, silence and discomfort of the bush.

"Suppose, to start with, half a million acres of land suitable for cotton growing were surveyed into 2,500 farms of 200 acres each. Each farm to be fenced and so many acres of land cleared and prepared for cotton

growing. A four-roomed cottage, with 10 ft. verandah all round, erected, a stove, a 2,000 gallon tank, an axe, etc., supplied. Opportunities given to acquire poultry, fruit trees, vegetable seeds, garden implements, a cow or a goat or two, etc. Wells could be sunk, if necessary, on each farm.

"Men experienced in cotton growing would supervise and advise the settler in the cultivation of cotton. Such men could be obtained from cotton growing areas in America or elsewhere. Families with children, penniless or otherwise, should be selected, as the children would pick the cotton, pending the production of a perfect cotton picking machine, which is being evolved in America. The settler would be charged nothing for his land, but the expense of surveying and placing him on his farm, of erecting fences, cottage, etc., and keeping him (if necessary) until his first crop of cotton should be charged against him. When he had paid off these expenses, with slight interest, the land, and all on it, should become his freehold.

"A warm climate offers many advantages over a climate with a cold winter for settlement purposes. Clothing, boots and fuel become an almost negligible quantity to the settler and his family, compared to that required in a climate where the winter is cold.

"Stock requires shelter only from the sun. Goats are cheap, and provide milk more wholesome than cow's milk. A township would be laid out, schools and churches erected, shops and so on, roads made and railway, of course. The difficulties mentioned are thus largely obviated by system and compact settlement."

Queenslanders have just as much dislike for your southern Victorian climate as M.B. (Melb.) appears to have for the North Australian sunshine.

May I refer M.B. (Melb.) to page 334 of the *British Medical Journal*, August 28, 1915, to a leading article entitled "The White Man in the Tropics"?

Surely the opinions of Sir Patrick Manson and of General William C. Gorgas, the latter of Panama fame, have weight?

General Gorgas' words are "This condition at Panama, I think, will be generally received as a demonstration that the white man can live and thrive in the tropics."

Australian conditions are infinitely superior to those of the Panama, nor is any part of Australia, except an infinitesimal portion, north of latitude 12; nor is anywhere the moisture pressure such that a white man cannot work in it.

The following is copied from a recent article in the *Melbourne Age*:—

| Country. | Average Life. | Natural Increase. |
|---|---------------|-------------------|
| Australia and New Zealand.. | Over 55 years | 17 |
| United Kingdom, Norway and Sweden | 53-54 | 10-12 |
| Denmark and Holland | 50-52 | 14 |
| Germany | 44 | 13 |
| Italy, Austria, Japan | 37-39 | 10-12 |
| Servia, Bulgaria, Roumania, European Russia | 35 | 16 |

The Australian evidently has a greater resistance to disease, or germs have a lesser degree of virulence in Australia, thanks to the sunshine, than is the case, say, of Great Britain, as proved by the lower death rates in Australia.

Yours, etc.,

NORMAN PERN.

Port Fairy, November 18, 1915.

OPERATION FOR VARICOCELE AS A MILITARY REQUIREMENT.

Sir,—Dr. Clarence Read, in his letter published in the *Journal* on November 6, says he read Dr. Scot Skirving's letter with interest. It seems to me that Dr. Read, though he read Dr. Skirving's letter with interest, has missed the point of Dr. Skirving's letter. Dr. Read writes of varicocele as a pathological condition. He cites the case of a soldier who had to wear a suspender. This man, when he lost his suspender, became useless, and had to be operated

on. This man, following an occupation involving manual work, would almost certainly have to wear a suspender or be operated on. No medical man, I should think, would waste time in discussing whether an operation was necessary on a man such as Dr. Read's patient, for military service. Dr. Scot Skirving drew attention to a totally different condition—men who are said by the military authorities to be suffering from varicocele, men who do not know the condition exists, who suffer no inconvenience whatsoever.

Dr. A. J. P. Chapman, in the *Journal* of 4/9/15, gives an excellent example of the class of case: "A young man of 27, with a chest expansion of six (6) inches, sound in every way, and accustomed to hard farming work from daylight to dark, without suffering the slightest inconvenience from varicocele, could not pass for this reason. For strength and endurance this man was regarded as the pick of the district."

Dr. Scott Skirving's own words were: "But I ask, is this condition frequently so severe as to be a bar to active military service, and to require an operation for its cure before acceptance as a combatant. I venture to think not. In the large majority of cases the amount of trouble is in truth negligible. . . . Of these surgical crimes I regret to say that I have committed eleven, and in not one of these cases in civil practice and normal times would I have advised the operation."

Dr. Farmer, in the *Journal* of 21/8/15, has given the profession Sir Frederick Treves's opinion re varicocele.

Rutherford Morrison gives the following indications for operation:—

(1) A large varicocele, with pain on standing or after exercise, and increased by hot weather or by sexual excitement.

(2) Service Demands.—Many young men otherwise eligible, are refused admission to the public service for a small varicocele. It is necessary for their admission that this should be removed, though there are no surgical indications for the operation.

Dr. Scot Skirving has asked: Why should service demand?

Dr. Read says perhaps not the lesser danger it removes a reason for malingering, which is a thing not unknown, particularly when a man is put on heavy duty which does not suit his taste.

The malingering cry is a very pretty cry. It stops all further argument. Tradition says: "The man may mangle, therefore the man must be operated on." Even with the fetish worship of varicocele is malingering utterly unknown in times of peace? Why accept any man? May he not mangle? Let us be ill-natured for one moment: A man with a very slight varicocele causing no symptoms, may mangle. The medical man cannot tell whether the man is malingering or not; therefore, to protect the doctor the man has to be operated on. This is, I admit, a hardly fair argument, and I do not use it. I only cite it as how the argument may be used against the profession. Dr. K., if he reject Bill Jones: "Well, Jones, you are a pretty good stamp of a man, but you know you have a slight varicocele, we cannot take you, you might mangle," need not be astonished if Jones says: "Well, doctor, you doctors cannot know much about your work or you would know whether a man was a malingeringer or not."

Force of circumstances has compelled the authorities to alter their views as regards hernia, height and teeth. At the outset of the war the authorities absolutely refused to look at a man who had been operated on for hernia. The regulation was "except operation for hernia, after which operation no candidate will be accepted." It was only after nine months of strenuousness, when the demand for men was daily increasing, that the authorities were able to recognize that a man who had been operated on for hernia might be of some use to the Empire. It required the same time for the authorities to realize that a man with a plate of artificial teeth might be useful. It needed the same time to permeate into the minds of the authorities the common sense fact that a sound healthy man need not necessarily be classed as physically unfit because he happened to be 5ft. 2in. instead of 5ft. 2½in. Remembering these facts, it seems to me that any medical man is justified in asking

if the present system of the authorities with regard to varicocele (the system which converts slight anatomical variations into pathological conditions, and in doing so rejects men such as described by Dr. Chapman) is the best way to support:

"Your King asks you,
The Empire needs you,
Australia calls you—come!"
Yours, etc.,

Killarney,
November 13, 1915. F. W. HARLIN.

THE CASE OF CAPTAIN SCHLINK.

Sir,—Dr. Thompson's letter voices the opinion of many others. Because a man happens to be a member of the medical profession there is no need to uphold whatever he does. In this case it is self-evident Dr. Schlink should not have been appointed to the position he held, and, so far as I recollect, evidence was given that he had uttered pro-German sentiments.

Another instance of the overlooking of wrong done by a medical man was afforded in the case communicated to you in which a doctor charged a poor beggar trying to enlist £40 for attending to his varicose veins. Not one word of protest did your journal offer against this callousness. Why not do something to show up this rotter, or at least let us have his name?

Yours, etc.,
F. J. NEWMAN.

"Kooyong," Geelong,
November 15, 1915.

Proceedings of the Australasian Medical Boards.

NEW SOUTH WALES.

The following have been registered under the provisions of the "Medical Act, No. 29, 1912," as duly qualified medical practitioners:—

Aspinall, William Robert, M.B., M.S., 1915, Univ. Sydney.

Bateman, Charles Daubeney, M.B., 1915, Univ., Sydney.

Brown, John Herald Balfour, M.B., M.S., 1915, Univ., Sydney.

Coppleston, Victor Marcus, M.B., M.S., 1915, Univ. Sydney.

Denham, Howard Kynaston, M.B., M.S., 1915, Univ., Sydney.

Farrar, Frank Martindale, M.B., M.S., 1915, Univ., Sydney.

Finlayson, Malcolm, Robert, M.B., M.S., 1915, Univ., Sydney.

Haynes, Raymond James, M.B., 1915, Univ., Sydney.

Hellstrom, Carl Oscar, M.B., 1915, Univ., Sydney.

Hughes, Roger Forrest, M.B., M.S., 1915, Univ., Sydney.

Jefferis, Robert Elbury, M.B., M.S., 1915, Univ., Sydney.

Kirkland, Hugh Edward, M.B., M.S., 1915, Univ., Sydney.

Leeds, Robert Harvey, M.B., M.S., 1915, Univ., Sydney.

Loxton, Edward Hamilton, M.B., M.S., 1915, Univ., Sydney.

Maher, Herbert Odillo, M.B., M.S., 1915, Univ., Sydney.

Moreau, Samuel Joseph Henry, M.B., M.S., 1915, Univ., Sydney.

Murray, Cedric Walter Wilberforce, M.B., M.S., 1915, Univ., Sydney.

Parker, Keith Shelley, M.B., M.S., 1915, Univ., Sydney.

Solling, Fritz Peter Max, M.B., M.S., 1915, Univ., Sydney.

Uren, Cecil, M.B., 1915, Univ., Sydney.

Van Someren, Bertram, M.B., 1915, Univ., Sydney.

Voss, Paul Ernest, M.B., 1915, Univ., Sydney.

Woolnough, Sydney James, M.B., M.S., 1915, Univ., Sydney.

Railton, Stanley Arthur, M.B., 1915, Univ., Sydney.

Drake, Dennys John, Lic. Lic. Mid R. Coll. Phys., Lond., 1896; M.R.C.S., Eng., 1896.

Weir, Laura, M.B., 1906, B.S., 1907, Univ., Melb.

For Additional Registration.

Martin, Walter Wallace, M.S., 1915, Univ., Sydney.

QUEENSLAND.

The following have been registered under the provisions of the "Medical Act of 1867" as duly qualified medical practitioners:—

- Cameron, Gavin Holme, Brisbane General Hospital, M.B., 1915, Univ. Syd.
 Dubig, James Vincent Joseph, Ipswich, M.B., 1914, Univ. Syd.
 Hill, Gordon Fitz, General Hospital, Brisbane, M.B., 1915, Univ. Syd.
 Minty, Cyril Charles, Warwick Hospital, M.B., 1915, Univ. Syd.
 Qulity, William Dempsey, Mater Misericordiae Hospital, South Brisbane, M.B., 1915, Univ. Syd.
 Reye, Albert James, General Hospital, Brisbane, M.B., Ch.M., 1915, Univ. Syd.
 Additional Qualification—
 Leavy, Edward Peter, Innisfail, F.R.C.S., Irel., 1915.

Medical Appointments.

Dr. J. W. Barrett has been nominated for re-election to the University Council, Melbourne.

Dr. J. E. Thomson has been appointed to act as Deputy Commissioner of Public Health, Queensland, during the absence of Dr. J. I. Moore.

Dr. Edward Angus Johnson has been appointed Deputy Inspector-General of Hospitals for South Australia during the absence of Dr. B. H. Morris.

The following announcement has been published in the South Australian Government Gazette, No. 46, of November 11, 1915: "His Excellency the Lieutenant-Governor in Council has been pleased to appoint William Allen Hunter, M.B., of Salisbury, and John Pengelly, of Meningie, to be Public Vaccinators."

The termination of the appointment of Dr. Edgar Jabez Brown as Deputy Inspector-General of Hospitals, South Australia, has been announced.

Medical Appointments Vacant, etc.

For announcements of medical appointments vacant, assistants, locum tenentes sought, etc., see "Advertiser," page xi.

- Royal Alexandra Hospital for Children, Camperdown, Honorary Relieving Medical Officer.
 Thargomindah Hospital, Medical Officer.
 Jundah Hospital, Q., Medical Officer.
 Hampden District Hospital, Friesland, Queensland, Resident Medical Officer.

Books Received.

- AIDS TO PHYSIOLOGY, by John Taft, M.D., D.Sc., and R. A. KRAUSE, M.D., D.Sc., 1915. London: Baillière, Tindall and Cox. Fcap., 8vo., pp. 242. Price, 3s. net.
 THE NATIONAL UNIVERSITY OF IRELAND, CALENDAR FOR THE YEAR, 1915; demt 8vo., pp. 583.

Diary for the Month.

- Nov. 30.—Victorian Branch, B.M.A., Eye and Ear Section.
 Nov. 30.—N.S.W. Branch, B.M.A., Organization and Science Committee, Medical Politics Committee.
 Dec. 1.—Victorian Branch, B.M.A., Annual General Meeting.
 Dec. 8.—South Sydney Medical Association, N.S.W.

- Dec. 8.—Melbourne Pediatric Society.
 Dec. 9.—Victorian Branch, B.M.A., Council.
 Dec. 10.—Queensland Branch, B.M.A., Annual Meeting.
 Dec. 14.—Tasmanian Branch, B.M.A., Monthly and Council.
 Dec. 15.—Victorian Branch, B.M.A., Clinical.
 Dec. 17.—N.S.W. Branch, Ordinary.
 Dec. 17.—Queensland Branch, B.M.A., Council.
 Dec. 21.—N.S.W. Branch, Executive and Finance Committee; Ethics Committee.
 Dec. 28.—Organization and Science Committee; Medical Politics Committee.

Important Notice.

Medical practitioners are requested not to apply for any appointment referred to in the following table, without having first communicated with the Honorary Secretary of the Branch named in the first column, or with the Medical Secretary of the British Medical Association, 429 Strand, London, W.C.

| Branch. | APPOINTMENTS. |
|---|--|
| QUEENSLAND. (Hon. Sec. B.M.A. Building, Adelaide Street, Brisbane). | Brisbane United F.S. Institute. |
| WESTERN AUSTRALIA. (Hon. Sec. 230 St. George's Terrace, Perth). | Swan District Medical Officer. All Contract Practice Appointments in W.A. Arncliffe F.S. Lodges. Australian Natives Association. Balmain United F.S. Dispensary. Burwood District F.S. Institute. Canterbury United F.S. Dispensary. Goulburn F.S. Association. Leichhardt and Petersham Dispensary. M.U. Oddfellows Med. Inst., Elizabeth Street, Sydney. Marrickville United Friendly Societies' Dispensary. Mullumbimby District Friendly Societies. N.S.W. Ambulance Association and Transport Brigade. N. Sydney United F.S. People's Prudential Benefit Society. Phoenix Mutual Provident Society. F.S. Lodges at Casino. F.S. Lodges at Limgow. F.S. Lodges at Mudgee. (except A.H.C.G. & M.U.I.O.O.F.) F.S. Lodges at Orange. F.S. Lodges at Parramatta, Penrith, and Auburn. F.S. Lodges at Wellington. Newcastle Collieries—Killingworth. Seaham Nos. 1 and 2. West Wallsend. |
| NEW SOUTH WALES. (Hon. Sec. 30-34 Elizabeth Street, Sydney). | |
| SOUTH AUSTRALIA. (Hon. Sec. 3 North Terrace, Adelaide). | The F.S. Medical Assoc. Incorp. Adelaide. |

EDITORIAL NOTICES.

Manuscripts forwarded to the office of this Journal cannot under any circumstances be returned.

Original articles forwarded for publication are understood to be offered to *The Medical Journal of Australia* alone, unless the contrary be stated.

All communications should be addressed to "The Editor," *The Medical Journal of Australia*, B.M.A. Building, 30-34 Elizabeth Street, Sydney, New South Wales.